PROGRESS IN INTERNATIONAL NUTRITION AND HEALTH

HEARING

BEFORE THE

INTERNATIONAL TASK FORCE

OF THE

SELECT COMMITTEE ON HUNGER HOUSE OF REPRESENTATIVES

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PROGRESS IN INTERNATIONAL NUTRITION AND HEALTH

THURSDAY, MAY 14, 1987

HOUSE OF REPRESENTATIVES,
INTERNATIONAL TASK FORCE,
SELECT COMMITTEE ON HUNGER,
Washington, DC.

The task force met, pursuant to call, at 10 a.m., in room B-318, Rayburn House Office Building, Hon. Tony P. Hall (chairman of the task force) presiding.

Member present: Representative Dorgan.

OPENING STATEMENT OF HON. TONY P. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. HALL. I'd like to call this task force together this morning. I want to thank all of you for coming. My name is Tony Hall, and I am chairman of the International Task Force of this Select Committee on Hunger.

It has been my pleasure to bring together the distinguished panel of witnesses we have before us today to discuss issues of nutrition and health which affect the lives of hundreds of millions of people every day.

The International Task Force of this committee has been active in studying and making recommendations to the Congress on these vital matters now for some years. We have participated in efforts to increase funding for child survival initiatives carried out by the Agency for International Development, UNICEF, and the private voluntary organizations who assist in carrying out these important activities. And we have been successful in those efforts.

In 1984 Congress established the Child Survival Fund, specifically to support basic health care in developing countries. We were instrumental in securing that funding. In 1985 and again in 1986 we prevailed in maintaining high levels of attention to and support for basic health and nutrition with legislation highlighting the universal child immunization campaign and the newly emerging evidence on vitamin A programs.

We are very proud of these efforts. In this year, for the first time, the administration has affirmed Congress support for these initiatives by not cutting its request for the Child Survival Fund from the level Congress appropriated last year.

We are very pleased to be able to thank AID for sustaining its Child Survival Program even in the face of overall declining funds for foreign assistance.

Also this year the International Task Force has been concentrating attention on issues of child survival which are not direct health programs, but which are very important to whether children live or die in Third World countries. For example, the most important factor in determining levels of infant and child mortality in these countries is the level of the mother's education. Only when women have sufficient access to information and assistance are they able to overcome such difficult barriers to child health as unclean water, unsanitary housing, and desperate poverty that so many of the people of the world today face.

A World Bank study found that every additional year of a mother's schooling decreased infant mortality by 6 per 1,000 births. Another study in India found that infant mortality rates fell from 188 to 115 per 1,000 among women who had completed primary school.

Therefore, Mr. Bereuter, vice chair of this task force, and I have worked to increase funding made available to AID for the purpose of expanding basic education programs.

We appreciate the efforts of the agencies and the organizations represented today in ensuring that basic health and nutrition needs are met. We look forward certainly to the testimony of the very distinguished people that we have before us.

We have two panels today. What I would like to do is have the two panels give their testimony and then answer some questions. The first panel is made up of Mr. Brad Langmaid, who is the Deputy Assistant Administrator in the Science and Technology Bureau of the Agency for International Development; and Dr. Richard Jolly, who is the Deputy Executive Director of the United Nation's Children's Fund, better known as UNICEF.

The second panel would be concerned with vitamin A, as well as other aspects of child nutrition. It would be made up of John Palmer of the Helen Keller International; Dr. Sommer of Johns Hopkins University; and Rudolph von Bernuth, director of planning of CARE.

Before we start with our first panel, I would like to make it clear that Dr. Jolly's appearance does not constitute a report to the Congress. This is an occasion in which we are able to profit from the information Dr. Jolly is sharing in order to raise public awareness of UNICEF's contribution to child survival and development.

We will hear from Mr. Langmaid first, from the Agency for International Development.

STATEMENT OF BRADSHAW LANGMAID, DEPUTY ASSISTANT ADMINISTRATOR, SCIENCE AND TECHNOLOGY BUREAU, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. LANGMAID. Thank you, Mr. Chairman, it's a pleasure to be here. I apologize that my statement arrived later than it should have, so I'll summarize what I think are the key parts of it.

This is the third time that this select committee has held hearings on child survival and the third time that a representative of the Agency for International Development has testified before this committee on our child survival programs. We appreciate your continued support for this program and welcome your interest in its progress.

I might also say it's a pleasure to share the table with Dr. Jolly. I think it symbolizes more than anything I might say the kind of cooperation that we have with both UNICEF and the other organizations that are joined together in this international effort.

To support its Child Survival Program, the Agency has adopted a multiaccount strategy drawing on the Child Survival Fund, the Health account, Economic Support Fund, and the African Fund. As a result, the total of all accounts supporting child survival activities has grown from $124 million in fiscal year 1985 to $150 million in fiscal year 1986. And we estimate approximately $150 million in fiscal year 1987 and 1988.

As you noted in your opening remarks, we intend to continue this level of support with the Child Survival Fund and with the overall health account.

Our goals are ambitious. AID's goal is to reduce infant mortality to below 75 for every 1,000 newborn infants. There is evidence that infant mortality is coming down. But even at 75 deaths per 1,000 births, it is still nearly 8 times the rate of the United States.

We have set similarly ambitious goals for extending essential child survival services. AID's objectives are to make oral rehydration therapy (ORT) universally available and to help countries move toward immunization of at least 80 percent of their children and sustain that coverage. We think excellent progress is being made in that regard.

As I noted a few minutes ago, this is truly an international, multinational and multidonor and multiagency effort. UNICEF, the World Health Organization, and AID enjoy close and collaborative working relationships on child survival programs. Private and voluntary organizations, including Rotary, CARE, Save the Children, universities and many other groups have joined in this historic effort. There is strong public and private support.

The results that can be reported are particularly gratifying. To give you a few examples: In Honduras, there has been a 40-percent decrease in deaths associated with diarrheal disease. Over 90 percent of the population is vaccinated against polio and 80 percent against measles, diphtheria, and whooping cough.

In Ecuador in 1986, immunization of children in the ages 12 through 23 months rose from 40 percent to nearly 80 percent at a cost of approximately $20 per child.

In Zaire, measles immunizations has increased on average of 24 percent each year for the past 3 years. Child survival services are accessible to 60 percent of the population.

Turkey delivered 27 million doses of vaccines in a 1986 campaign. That's at least doubling its precampaign coverage—in Egypt, the national ORT Program increased ORT usage to 65 percent, a success credited with saving many thousands of lives.

Many of these accomplishments, Mr. Chairman, are summarized in the Agency's Child Survival Second Report to Congress, which I think has been sent to all the members of the committee. With the committee's permission I would like to have this inserted in the record as a more permanent summary of the activities of the Agency's Child Survival Program.

[The report referred to above retained in committee files.]

Mr. LANGMAID. Even as we have success in sight, we must be concerned with how to sustain the gains we have made. Programs launched with enthusiasm face the day-in, day-out challenge of sustaining the delivery of these essential services, and in an era of contracting budgets, finding the resources to support them.

International experts now estimate that deaths due to vaccine preventable diseases and dehydration were reduced by 1.5 million last year. UNICEF predicts that over 11 million children, more than the entire school age population of New England and the West Coast, could be saved by the year 2000 by the systematic and continued application of these interventions.

The support from this committee has been vital to this effort. Full success depends on your continued commitment and that of your counterparts overseas, of international organizations, and the public and private agencies to this unprecedented alliance for the welfare of children.

I think, Mr. Chairman, in concluding, the Child Survival Program represents a striking example of what development assistance can do. These interventions consistently applied can have dramatic consequences. They can raise the hope of people around the world and achieve dramatic results. They must be sustained.

What we are finding as we approach the targets we've set for ourselves, is that the first 20, the first 40, even the first 50 percent of coverage or access is relatively easy to achieve. As you get closer to the higher levels you run into all the endemic problems of a developing society, all the institutional problems, all the problems of maintaining momentum.

We think we have a program that works and is making a real difference. Our urging to your committee, as our urging to our own staffs is that we stay the course so that we can achieve the results we've set for this program.

Thank you, Mr. Chairman.

Mr. HALL. Thank you, sir.

[The prepared statement of Mr. Langmaid appears at the conclusion of the hearing, see p. 26.]

Mr. HALL. Mr. Jolly, from UNICEF.

STATEMENT OF RICHARD JOLLY, DEPUTY EXECUTIVE DIRECTOR, UNITED NATIONS CHILDREN'S FUND [UNICEF]

Mr. JOLLY. Thank you very much, sir. It's a particular pleasure and privilege to appear once again before this committee. It was at the first public hearings of this committee 3 years ago that Mr. James Grant, the executive director of UNICEF, outlined the potential for a child survival and development revolution.

This committee, as we in UNICEF well know, is the committee which has followed and encouraged U.S. AID's own leadership and support in child survival, and it is this committee which has sustained the leading role taken by Congress in this global effort.

Indeed, if I may say, sir, coming from a country which looks with pride on Westminster as the mother of parliaments, I gladly acknowledge that it was the U.S. Congress which was the first national legislature in the world formally to endorse and encourage

the child survival and development resolution through its joint resolution of 1983.

The accomplishments of child survival and development, now in its 5th year, are indeed dramatic. It is estimated that the lives of over 4 million children have been saved in these 5 years. The health of tens of millions more has been significantly improved.

The promotion of immunization and oral rehydration, the leading edges of this revolution, alone have saved the lives of an estimated 1.5 million children in 1986. Today's low-cost methods provide the capacity to save the lives of more than 7 million children every year.

We are well on our way, though success is still far from guaranteed, toward the United Nations' goals of universal child immunization by the year 1990. And just last week the World Health Assembly formally embraced the ORT goals of universal access to and 50 percent use of ORS's [oral rehydration salts] by the end of this decade, a goal which was first proposed by U.S. AID administrator, Peter McPherson, at the conclusion of the historic second ICORT, International Conference on Oral Rehydration Therapy, here in Washington in December 1986.

The record of this progress, Mr. Chairman, is documented in a report which we submitted to UNICEF's executive board, entitled "Progress Review of the Child Survival and Development Revolution, 1983 to 1986," a copy of which I would like to submit for this committee's record. And may I also take the chance to commend the U.S. AID's. Second Report to Congress on Child Survival, and inform this committee that we circulated a copy of that report to all members of UNICEF's executive board when they were meeting in New York 3 weeks ago.

[The progress review referred to above retained in committee files.]

Mr. JOLLY. Mr. Chairman, for the sake of time, I won't recite here various country examples, although in my written statement I refer to some exciting progress in Brazil, a number of countries of Africa, Indonesia, and last month UNICEF's executive board accorded our highest honor, the Maurice Pate Memorial Award—named for UNICEF's first executive director—to the Catholic church in El Salvador on behalf of all the Salvadoran people who have joined together in the past 3 years, despite sharp political differences and conflict, to protect their children from the greatest danger, disease.

And through the dedicated efforts of the church, as well as many private organizations and institutions, and with the support of both the government and the rebel forces, El Salvador last month observed it's 9th day of tranquility allowing the national vaccination campaign to reach all the country's children.

Since its initiation in February 1985, this immunization program has saved the lives and prevented the crippling of more than 10,000 Salvadoran children. The immunization rate has risen from 40 to 80 percent. The El Salvador program has led to an unprecedented Central American bridge to peace initiative, jointly supported by WHO and UNICEF—with all seven countries, with their heads of state, participating last month in a multinational immunization day.

Mr. Chairman, we now count over 80 countries that have undertaken accelerated immunization programs and are doing their best to achieve the United Nation's goal of universal child immunization by 1990.

If I had to choose two indicators of achievement, I would draw the attention of this committee to first the declining global incidence of measles, tetanus, and polio, as shown in the data from the World Health Organization, given in figure 1 page 17 of the progress review I have just submitted to this committee.

And, second, to the WHO estimate, which I just quoted, that the deaths of some 1½ million children under 5 were prevented in 1986 by these two measures, immunization and oral rehydration therapy, as indicated on pages 26 and 39 of our report.

Mr. Chairman, may I, however, underline one remarkable feature of this expansion in child survival and development actions. It is a fast acceleration upward of basic health action at a time of severe economic crisis which affects at least two-thirds of the developing countries of Africa, Latin America, and Asia.

In these countries GNP, incomes, health budgets, and production have declined, and declined often by 10, 20, or more percent. So the expansion we're seeing in these health actions is an expansion against the trend, and therefore implies a restructuring of priorities of the sort which is even more needed because of the economic crisis.

In this respect it is the leading example of what UNICEF refers to as adjustment with a human face. That is, an economic approach which urges greater attention to human needs and protection of vulnerable groups as a matter of poor economic policy nationally and internationally.

The urgency of increasing attention to human needs in the course of adjustment policy has, we are pleased to report, been gaining wider acceptance among many international institutions; notably including the World Bank and last July in a statement by Mr. de Larossiere, the managing director of the International Monetary Fund, but also the World Health Organization and the International Fund for Agricultural Development [IFAD].

We see these issues of adjustment with a human face as a way of extending out these positive examples of health immunization, ORT, and others, into many other areas of basic economic policy.

Mr. Chairman, what lessons can one draw from this positive expansion at a time of economic crisis? The paper circulated to you identifies four major factors which UNICEF, reporting to our board, felt ought to be underlined as explanations of this dramatic progress at a time of great strength.

First, the generation of political will by seeking and winning support for these child health actions at the highest political level. Second, social mobilization of entire countries; that is, using the mass media and a multitude of social organizations, private and voluntary organizations, national and international, to mobilize for the outreach.

And in my report I expand upon some of the extensions of this social mobilization and our hope that what we have seen so successful in these areas of basic health action can indeed be turned to

other related areas such as water, improved sanitation, literacy for women, basic education, and so forth.

Third, we have seen the needs and the reinforcement of basic child health actions which comes by building strong program linkages with other programs in the area particularly of primary health care.

And, fourth, we have seen the importance of international collaborative partnerships in support of these actions.

I'd like to say a word before closing, Mr. Chairman, on this partnership internationally and nationally. Little of what has been accomplished in these past few years would have been possible without the invaluable work of a number of other international U.N. organizations, including the World Health Organization, the United Nations Development Program, and the World Bank.

In addition to the United States, we have seen many bilateral assistance agencies play a major part, including Australia, Canada, Denmark, Finland, France, Italy, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom, and the aid agency of the European economic community.

We have also seen the coming of age as major participants in the development process of thousands of international and national voluntary organizations and associations, including on the global level, the International Pediatric Association, the World Federation of Public Health Associations, the International League of Red Cross and Red Crescent Societies, and Rotary International.

It is for this reason, Mr. Chairman, that it's a pleasure to be here. And soon afterward, the contributions of CARE, the contributions of universities to this effort will be reported on directly by their own representatives.

If I might just note that in addition to the funding provided through the U.S. Congress, and to some extent inspired by it, the Government of Italy has now committed $130 million to support multiyear child survival programs in 26 African countries, 7 Central American countries, and 3 Asian countries.

Similarly, the Government of Canada established a $35-million commonwealth fund and special fund for Francophone countries in Africa in support of UCI. I've already mentioned others.

Mr. Chairman, the continued support and encouragement of the U.S. Government and its agencies, in which this committee and the Congress play a vital role, will surely determine whether we actually achieve our great goals for 1990 and beyond, and whether humanity's most precious resource, children, receive the protection they so urgently need in their earliest years.

This committee has recognized the value of that early investment already. I know that you will continue to do so in the years ahead.

Thank you.

Mr. HALL. Thank you, Mr. Jolly, for a very good statement.

[The prepared statement of Mr. Jolly appears at the conclusion of the hearing, see p. 38.]

Mr. HALL. You know, as I listened to both of you and as I look at the statistics, I'm excited to see that Congress has passed this resolution, the first country in the world to do this. We started a few

years ago to join this universal effort to immunize the people of the world, mostly the children.

But what's really exciting is to see a project in which so many groups, U.S. AID, UNICEF, Congress, private and voluntary organizations, have worked together and not really tried to take the attention away from the other, but have worked together to bring these infant mortality rates down. And this is a real exciting success story that countries and groups have joined together to accomplish something that's so meaningful, to save so many lives.

It's amazing how it's come together, that they've all really worked together, they're all working together, to solve this problem. And it's exciting to have oversight hearings to hear about this. We still have some problems, of course, and we have a long way to go, but at least it's started and we can see some results and it's successful, and not one person or one group is carrying the ball, but all of them are working together. It's exciting.

Mr. Langmaid, I also want to commend AID for its work in child survival. I think they've made great strides toward immunizing and working toward proper health techniques and proper nutrition in the world. They are to be congratulated.

This child survival report is a good report. There are some questions that I'd like to ask about it. The last part is somewhat confusing relative to the 1986 Child Survival Action Program. We have claimed a total of $150 million in 1986 that was spent on child survival activities, but I only see outlined in the back of the book $36 million. I wanted to know if you have a proper break down of the rest of the—it's a little bit over $113 million.

Mr. LANGMAID. I'd be glad to submit that, Mr. Chairman. What you have in the report, because it was mandated by the Child Survival legislation, is the Child Survival Fund summary. The balance comes from the health account, the ESF account, the Sahel account and then, in the future, the Africa Fund. But we can break those down.

Mr. HALL. I would like to see that broken down, especially the ESF, the nutrition account, and the agriculture account.

Mr. LANGMAID. As you can imagine, for example, in Egypt, which is one of our real success stories in the ORS field, it's entirely funded with ESF funds. So you have a large component in Egypt. You have that and also in Pakistan where we have major ESF-funded activities.

Mr. HALL. And you'll provide that in writing?

Mr. LANGMAID. I'll be glad to, Mr. Chairman.

Mr. HALL. Thank you. I also understand that the—out of the $75 million that's being allocated to Child Survival Fund in 1987, $75 million, this committee worked very hard for, $9 million of that is going to the United States private voluntary organizations, PVO community.

How will the remaining $66 million be spent? Do you have a break down of that?

Mr. LANGMAID. I'm not sure you want me to read the full table into the record.

Mr. HALL. No.

Mr. LANGMAID. But $14 million of it will go to the Africa region in Kenya, Niger, Sudan, Uganda; $12 million goes to the ANE area;

and $24 million to the Latin American area. I have a project-by-project break down that I'd be glad to insert into the record for you, Mr. Chairman. These are immunization programs and ORT programs.

Probably the largest single activity is the CCCD expansion program in Africa. This is the large regional immunization activity in the Africa region. But it's a variety of projects.

Mr. HALL. One thing I'm very concerned about is that Congress specifically has stated that the one purpose of the Child Survival Fund was to make these funds available to the PVO community. And a small portion of the $75 million is going to the PVO community.

We have stated that time and time again in our committee hearings, task force hearings. We have stated it in the committee language. We like what the PVO community is doing. We like their efficiency, their nonpartisanship, we like their cost-effectiveness. And it is a concern to me that only $9 million of that $75 million for 1987 is going to the PVO community. At least that's what it looks like to me right now.

Mr. LANGMAID. Mr. Chairman, I think the $9 million understates the total that's involved here. The $9 million really is the amount set aside specifically for the competitive PVO grants activity and managed by our Office of Private and Voluntary Organizations.

In addition a variety of PVO activities are done through our bilateral programs in the field, as well as with organizations such as UNICEF. Our estimate, and I'd be glad to give this to you also in detail for the record, is roughly 67 percent or around $24 million of the total Child Survival Fund of $36 million in fiscal year 1986 was provided to PVO's and NGO's. Altogether, AID provided $38 million to U.S. PVO's in fiscal year 1986 for health and child survival activities from the child survival, health, and food and nutrition accounts. For fiscal year 1987 our information at this point in the fiscal year is incomplete. However, reports already indicate commitments to PVO's and NGO's from the child survival account of $28.7 million and total commitments to U.S. PVO's for health and child survival activities from the child survival, health, and food and nutrition accounts of $33.1 million.

Mr. HALL. I'd like to see that broken down, too.

Mr. LANGMAID. I'd be glad to.

Mr. HALL. Mr. Dorgan, do you have any questions of Mr. Langmaid?

Mr. DORGAN. I'd like to ask Mr. Jolly a question.

Mr. HALL. Go ahead.

Mr. DORGAN. Mr. Jolly, I've been interested in the UNICEF program and the initiative for a long while, and particularly the early work on ORT and Child Survival Fund. A year or two ago, 3 years perhaps, we were hearing discussed the aggregate amount of money that could be invested to save a number of lives across the world. As I recall, it was $1 billion a year that was being discussed for the Child Survival Fund.

I might be wrong, but could you give me some idea of what the aggregate amount of the money is now being spent on the Child Survival Fund on all sources? Will you refresh my memory on the numbers used previously with respect to the Child Survival Fund?

Mr. JOLLY. I fear I can't give either with great precision. One of the problems, of course, is do you mean international support, or do you mean national government support? All the immunizations and ORT or other primary health care actions are largely funded from local resources by the governments concerned—notwithstanding, as I indicated, that government budgets are being cut back.

So the international support is the tip of the iceberg. We are preparing for our board next year a paper on the financing of the child survival and development action with particular attention to the issue of sustainability, which will take us into the issue of national funding.

And without that study, I'm afraid I can't give a simple set of figures. I did quote in my statement the total sums of money which various international donor agencies have provided specifically for immunization activities. But, of course, this misses out a great deal of what they may be providing for primary health care activities in different ways.

Mr. DORGAN. Well, that was sort of a shapeless question anyway.

Mr. JOLLY. And please excuse the shapeless answer.

Mr. DORGAN. You know, I was sitting here thinking that the work that Congressman Hall has done in this area, it has been the best work of any in the House or the Senate in my judgment. I was sitting here thinking about your testimony and the enormous amount of good that can be done at relatively little cost.

And thinking about that in terms of the debate we had yesterday on just research on Star Wars, the debate was between a low of $1.2 billion, and the Presidential request of $5.7 billion. So, you know, the difference between that is $4.5 billion, and we're talking about research.

What would $4.5 billion mean to the kinds of things you're talking about at this table today, the quantity of good that can be done at such an incredibly small price measured against other foolish things that are being done. It's staggering.

I hope maybe some day we can make decisions seem as important in this area as they're made to seem, as they were made to seem yesterday in discussing Star Wars. I think saving children is much, much more important.

But I just wanted to say that I appreciate your work a great deal.

Mr. JOLLY. Thank you.

Mr. DORGAN. With respect to AID, I've not had a chance to read through your complete testimony, but I think we have seen in the recent times a real interest on the part of AID in pushing some of these programs. I don't think that interest has always been served fully by the administration, but I think the heart of AID has been in the right place, and we appreciate the work that you are doing and that has been done, and hope for much better work in the future on focussing on some of these problems.

Thank you very much.

Mr. HALL. Thank you, Congressman.

Mr. JOLLY. Mr. Chairman, may I make just one comment in relation to the comparison between military expenditure and health expenditure issue which has concerned UNICEF's executive board?

Mr. HALL. Yes.

Mr. JOLLY. And, indeed, in 1982, with the support of the U.S. Government and the U.S.S.R. delegation, UNICEF's executive board adopted a resolution on the need for shifting some resources from military expenditures to benefit the people, particularly the children. That was formally agreed by all board members—perhaps the only United Nations resolution on such issues that was supported by both the U.S. and U.S.S.R.

In that debate, reference was made to the fact that smallpox was eradicated from the face of this Earth over 10 years for a total expenditure of less than $100 million internationally and less than $200 million of national expenditure. A total at that time cost less than that required to buy three fighter bombers.

Mr. DORGAN. What period are you talking about?

Mr. JOLLY. This is 1966 or so to 1976. And over that period, for the cost of three fighter bombers, smallpox was eradicated. Without the eradication of small pox, some 2 million extra children would be dying each year, it is estimated.

And I know the U.S. Government has made estimates of how much extra expenditure the United States itself, alone, would be incurring simply to organize smallpox vaccinations, check people coming in at immigration, and so forth. One estimate I seem to recall was of the order of $1½ billion just for those services, over the period since smallpox was eradicated.

I would, if I might, also commend a publication issued privately, called World Military and Social Expenditures, edited by Ruth Leger Sivard, which is a factual compilation of both military expenditures for all countries in the world and health and education expenditures, and some comparisons of what might be gained if there could be some shift. It's a very impressive publication.

Mr. HALL. My office did a report on conventional arms buying a couple of years ago. We undertook it in the private sense because we were very interested in that, as opposed to that kind of buying versus the kind of expenditures that we'd be talking about today.

And as I remember the report, to feed and to cloth and to educate and to shelter and to provide the kind of programs we're providing today, this was about 4 years ago, it would take $18 billion to do it all across the world. This was put out by a report I think within the United Nations.

And, of course, the world spends that much every 2 weeks on arms. It was a very alarming statistic.

Mr. Jolly, I and all of us continue to see these very alarming reports on AIDS in Third World countries, particularly among children.

My question is, does the threat of this program impede immunization programs for children, and how does UNICEF address this?

Mr. JOLLY. Mr. Chairman, so far there is no evidence whatsoever to link child immunization or these other basic child health actions with AIDS. And in that sense I think the answer is no, it does not pose a threat.

But there is indeed a risk that there could be inappropriate association of immunizations with AIDS transmission, and this was a subject which was discussed at UNICEF's recent executive board, in addition, perhaps I should say, as well as at the Joint Committee

on Health Policy, which is a joint UNICEF-WHO body that includes board members from both organizations.

Following those discussions, a resolution was put forward on what UNICEF's policy should be in this area of AIDS. Perhaps I might just summarize the basic points.

First, that we would continue to work closely with WHO, and because of the complex technical issues involved, very much follow WHO's lead in this area. That is a very firm part of our policy.

Second, to ensure that nothing in our UNICEF supported immunization efforts in anyway runs any risk of contributing to the transmission of AIDS through contaminated needles. And as part of this we have been following clean, sterilization procedures and so forth. But we have sent further messages to the field with WHO, and have been discussing their application with governments in all their immunization efforts. Our instructions specify that all child immunizations should involve clean, sterile needles and a clean sterile syringe. And we have issued new instructions to our fields and are making provision for every country to have sterilization equipment.

If I might explain here, that contrary to what common sense might suggest, the policy of WHO which we follow is, wherever possible, government to use reuseable syringes and needles rather than disposable syringes and needles. I say contrary to common sense because you'd think that the safest system is disposables. The reality, of course, is that disposable needles and syringes are very often not disposed of, and, in fact, used again without any sterilization, and thereby run the risk of HIV transmission.

So our policy is to assist countries in moving to use reuseables, and to ensure adequate sterilization equipment and a sufficient supply of needles and syringes that each immunizing station has a full days supply, allowing them to do all sterilization in the evening, at the end of the immunizations for the day.

Perhaps I could also pay tribute here to U.S. AID's very important research work on the easy-ject, which is a non-reuseable—absolutely nonreuseable-disposable syringe. And I'm told that we are within very few months of having that available. If we can have that available, it will make a major difference worldwide on this.

Those are the elements relating to immunization efforts. Someone with medical knowledge could explain why there is actually less risk of child-to-child transmission of AIDS or in transmission through child immunization efforts than through other media of transmission.

For one reason, fewer children are infected than adults. It relates also to the nature of the injections mostly being subfrutaneous, and so on and so forth. But I would repeat what I said at the beginning, that WHO affirms that there is absolutely no evidence of AIDS ever having been transmitted by child immunization.

I want to briefly mention two other areas in our policy on AIDS. In relation to breast feeding, we follow WHO's lead here in encouraging breast feeding. The risk of death by not breast feeding is very high, as we know it relates to the whole diarrheal syndrome and so forth. So except in confirmed AIDS cases there is no reason whatsoever not to encourage breast feeding, and we have every reason to encourage it.

We feel in the area of education and communication, UNICEF's experience in social mobilization is very important and we hope some of that can be used indeed to tackle the only way of tackling AIDS, which is prevention by spreading messages of the need for prevention.

UNICEF will not be involved in research. This is very much WHO's area. I would conclude by expressing the great need for careful information in this area, lest quite inappropriate associations be drawn, and we jeopardize the great progress that has been made in bringing immunization already to save, as we said, some 4 million children which, of course, vastly, vastly outnumbers those who have died from AIDS.

We know that the answer for measles, for polio, are these immunizations.

Mr. DORGAN. Could I just ask another question, Mr. Chairman? You talk about saving 4 million children.

Can you refresh my memory again the population of children in the world that are not immunized? What's your target population of them?

Mr. JOLLY. Well, there are some 125 million children born a year at the moment and the target is to immunize all of them by the age of 1, 12 months. One needs to get the benefit particularly of measles immunization early

Worldwide coverage I can't quote a single figure. We give the regional estimates in the paper before you, and off the top of my head I can't calculate what the number of children immunized would be. But the target is universal immunization.

Mr. DORGAN. How many children die of measles in the world each year?

Mr. JOLLY. It was several years ago about 2.6 million and it's now down to about 2 million.

Mr. DORGAN. What's the cost of delivery of an immunization to one child?

Mr. JOLLY. Of course it varies by country. The cost of the vaccines is under $1 for a full set of vaccines for all six diseases, the basic six as proposed by WHO. The effective cost relates to the delivery system, the staff, the transport, and so on and so forth. We use a figure of $5, but in practice, as an average worldwide practice. If you look at particular countries which we are increasingly doing so, of course you'd get very different figures.

But, if I might, in terms of action, most of the process I said earlier are national processes which relates to getting the basic primary health care system of the country focused, delivering, and operating. That requires the use of local resources, obviously to some extent salaries and others, and to the role of volunteers and organizations.

The international cost, the foreign exchange cost, is very much the vaccine and certain key bits of equipment; plus at a time of recession and cutbacks, as I've explained, things like supply of gasoline and so forth. It's not a lack of resources, but international support, particularly at a time of debt crisis for these foreign exchange elements is critical.

Mr. HALL. Mr. Langmaid.

Mr. LANGMAID. I might add that we do not have a worldwide emphasis. We have a developing world emphasis. So our numbers are a little different, but the framework we're operating in is roughly 14 million infant deaths in the developing world. Approximately half of those could be saved by immunization and ORT, and the shares within that are roughly 4 million could be saved by the full application of oral rehydration therapy, and 3 million roughly to immunization. That's sort of the ballpark that we're operating in if you want a framework.

Mr. HALL. Thank you. I have some other questions I'd like to submit to you, and we thank you for coming today, for your testimony. We're very interested, Mr. Langmaid, in your written statements on the PVO's, that 60 percent surprises me. So I'll be very interested to take a look at that.

Mr. LANGMAID. I'll be glad to.

Mr. HALL. I'd like to introduce the next panel. Mr. John Palmer, executive director of the Helen Keller International, will discuss his agency's involvement in child survival programs, particularly those addressed to reducing vitamin A deficiency.

And Dr. Sommer, from the Johns Hopkins University, will discuss his research findings from Indonesia and other countries which indicate the impact of vitamin A programs in eliminating nutritional blindness and dramatically reducing child mortality.

And then from CARE we have Rudolph von Bernuth, director of planning, who will discuss the role of CARE and other private voluntary organizations in programs to address child survival in developing countries.

So we'll go with Mr. Palmer, Mr. Sommer, and Mr. von Bernuth.

Am I pronouncing that correctly?

Mr. VON BERNUTH. That's fine. Thank you.

STATEMENT OF JOHN M. PALMER III, EXECUTIVE DIRECTOR, HELEN KELLER INTERNATIONAL

Mr. PALMER. Thank you, Congressman Hall. It's a pleasure to appear before this committee today. And as executive director of Helen Keller International, my special concern is that 65 million children in over 50 nations lack simple, but very essential nutrient, vitamin A.

This renders these children many times more susceptible to fatal infectious diseases. At the very least, it impairs their vision, leaving many permanently blind.

Two years ago, Representative Leland, yourself, and this committee convinced Congress to vote a 3 year, $24 million vitamin A earmark which began in February of fiscal year 1986, and which established vitamin A as an important strategy in our Nation's campaign for child survival.

My testimony today concerns the advances made possible in the past 2 years by U.S. funds for vitamin A and child survival, and demonstrates the immediate, still urgent needs to secure the third tier of the pledged vitamin A earmark in fiscal year 1988.

This is a success story, but one that's not completely written. And though I speak primarily for Helen Keller International, be assured that we are not alone.

Our agency, in close cooperation with UNICEF, the World Health Organization, CARE, distinguished universities led by Johns Hopkins University, and the community of private voluntary organizations is building high impact model programs in Africa and Asia for there are tens of millions of children at risk.

We are training thousands of health workers to prevent, protect and treat vitamin A deficiency. We are mounting nationwide awareness campaigns, determining if vitamin A supplements can be delivered at even less than 1 penny produce, and providing vitamin A supplementation in tandem with child survival strategies we've just heard about, immunization and ORT.

A particular example which we've discussed in brief is measles, the major cause of childhood death in Africa. It's now recognized that all children with measles, over 2 million, are in need of vitamin A.

In addition to these immediate measures there is now a very strong emphasis on long-term self-sustaining solutions to vitamin A requirements with industrial fortification of inexpensive, commonly used food stuffs and with social marketing to effect behavior change. For example, longer breast feeding and consumption of vitamin A rich vegetables. Policymakers worldwide are being made more aware of the significance of vitamin A deficiency and how to overcome it. And with earmarked funds, these activities are in full swing. We believe that we can realistically aim to bring them all up to national scale in many places.

The Philippines is now creating intensive vitamin A programming. Nepal is on the list. And, closer to home, Haiti has been added.

In addition to Helen Keller International's programs in three Sahel countries, we aim to achieve rapid coverage by providing technical assistance for other American private voluntary agencies who have child survival programs in Cameroon, Kenya, Malawi, Niger and Senegal. The children of Africa are in a special desperate need of this effective, very inexpensive intervention.

For the future Helen Keller International expects to quadruple the number of children reached and the sum of our experience will serve as the basis for disseminating to the public health community a series of practical and immediate strategies that can be replicated on a global scale.

A third year vitamin A earmark is essential for these key activities to be fully successful and for their cumulative effect to become apparent. This earmark is pivotal for the dissemination efforts that will carry vitamin A deficiency prevention methods and materials to public health officials around the world.

It is vital to accomplish in Africa what we have begun in Asia. It is essential to save the target population of 65 million children from sight threatening, life threatening tragedies that accompany vitamin A deficiency.

By providing funds designated for vitamin A activities, Congress is continuing our distinct contribution to child survival. The momentum created by the U.S. Government is reaching more and more vulnerable children. Vitamin A, because of our efforts, is now on the world's health agenda.

As Mr. Jolly noted earlier, it is an initiative of which we may be justifiably proud, but it is an effort that we cannot desert just as its true importance in saving lives is being felt.

Today we urge the select committee to maintain its commitment to provide a vitamin A earmark in fiscal year 1988. This earmark has already provided life saving vitamin A for the poorest children on Earth. The earmark is critically needed. Continued vitamin A is a part of child survival. This part is often underestimated and undervalued, but we must not allow any child in the Third World to be without it. The need simply cannot be overstated.

If we do not provide vitamin A, we can expect an annual toll of 500,000 children with eye signs of vitamin A deficiency so far advanced that they become totally blind.

As far as statistics go, that's one child every minute, and most of these die. But many more millions will succumb before they even go blind. These children cannot wait another minute. Today we urge that Congress should not hesitate another year.

Thank you.

Mr. HALL. Thank you, Mr. Palmer.

[The prepared statement of Mr. Palmer appears at the conclusion of the hearing, see p. 42.]

Mr. HALL. Dr. Sommer.

STATEMENT OF ALFRED SOMMER, M.D., DIRECTOR AND PROFESSOR, DANA CENTER, WILMER EYE INSTITUTE AND JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH

Dr. SOMMER. Thank you. It is a privilege to return to address the Select Committee on Hunger. The active support and encouragement provided through the Agency for International Development has done much to foster child health and survival among disadvantaged populations in general, and, in particular, has strengthened the research and intervention activities of a new approach to the problem that may prove exceedingly important and cost-effective.

A technique we recently developed for detecting early, but medically significant vitamin A deficiency, indicates that 25 to 50 million children may be suffering ill-effects of vitamin A deficiency every year.

The significance of even mild vitamin A deficiency for childrens' health and survival has been emphasized by completion of the study in North Sumatra, where mortality among all children in villages randomized to receive a single, large dose vitamin A supplement once every 6 months was 35 percent lower than among children living in villages where vitamin A was targeted only to those with obvious eye disease.

Of course, not all children in the program villages actually were available to receive their vitamin. When adjusted for those who did not get it, the potential biologic impact was an astounding 70 percent reduction in mortality.

Indeed, a greater than 35 percent reduction in mortality was observed in a recently completed vitamin A fortification program in Western Java, 1,200 miles away. In both the North Sumatra study and in the Western Java study, vitamin A supplemented children grew better than nonsupplemented children.

The fortification study also confirmed that vitamin A deficiency contributes to anemia. After 1 year of fortification, hemoglobin values of children in the program area rose by almost 10 percent.

The mechanism by which vitamin A exerts these beneficial effects is as yet uncertain. But in our studies in Indonesia, and ones that have followed in India, mildly vitamin A deficient children were at an increased risk of developing respiratory disease, a major childhood killer in Third World countries.

In Indonesia, vitamin A deficiency was also associated with an increased risk of developing diarrhea. In Tanzania, where like in much of Africa measles is a major cause of childhood deaths, a study we recently published demonstrated that children hospitalized with moderate to severe measles randomized to receive high dose vitamin A, died at only one-half of the rate of children randomized to the standard hospital regimen.

Finally, it was even found that in otherwise well nourished Australian children vitamin A deficiency increased the risk of lower respiratory disease and supplementation reduced it.

These results demonstrate in controlled fashion phenomenae observed in animals for years. That these can pertain to human populations in such large numbers and so dramatically has already resulted in a number of official actions by governments and international agencies.

The World Health Assembly voted that WHO give greater attention to the problem, and WHO has formulated a 10-year program.

The Subcommittee on Nutrition of the United Nations Action Coordinating Council concluded that a beneficial effect on child mortality was a likely additional expectation from vitamin A supplementation programs.

The Government of Indonesia concluded just last month that as many as 200,000 Indonesian children can be saved each year from vitamin A supplementation, and laid plans for a nationwide vitamin A fortification program.

UNICEF and the World Health Organization have just prepared a joint position paper recommending high dose vitamin A supplementation of all children with measles in communities in which vitamin A deficiency is recognized as a problem and even where it is not, wherever the case fatality rates from measles are 1 percent or higher, a common condition in Africa.

The potential benefits from vitamin A intervention are enormous, quite possibly affecting the nutrition, growth, health, and vision of 25 to 50 million children worldwide, and depending upon the severity of vitamin A deficiency and causes of mortality, the preventing of as many as 1 to 3 million childhood deaths and half a million children from going blind worldwide each year.

Spurred by these exciting results, and their implications for a relatively inexpensive, cost-effective approach to improving children's health, survival, and vision, dozens of countries worldwide are actively considering a wide variety of vitamin A initiatives.

Most programs are in their infancy. They require continued nurturing and support while governments test out the value of vitamin A supplementation for their citizens and devise the most cost-effective means of improving the vitamin A status of their young children.

The United States deservedly receives recognition for these remarkable developments. This recognition is accompanied, however, by a very special obligation. The United States generosity has permitted the rapid expansion of research and intervention activities.

Continued support is absolutely essential to bring these initiatives for saving childrens' sight and ensuring their survival to fruition.

I'd like to thank you for your continuing interest, encouragement and support.

[The prepared statement of Dr. Sommer appears at the conclusion of the hearing, see p. 44.]

Mr. HALL. Mr. von Bernuth.

STATEMENT OF RUDOLPH von BERNUTH, DIRECTOR, PROGRAM ADMINISTRATION, CARE, NEW YORK, NY

Mr. VON BERNUTH. Thank you, Mr. Chairman and respected guests and colleagues. CARE has traditionally had a strong institutional commitment to health which, of course, considerably antidates the present child survival programs.

Today, CARE's primary health sector consists of approximately 73 projects divided into four broad groups. Those groups are water supply and sanitation, integrated primary health care with multiple interventions without food components, maternal and child health projects including Public Law 480 food components, and education and training.

Included in CARE's 73 primary health care projects are six projects funded through the Agency for International Development Child Survival Program. In 1985, AID funded CARE projects in Bolivia, Haiti, Indonesia, and Uganda. In 1986, new projects were funded in Mali and Sudan.

Today I would like to discuss, first of all, the positive impact of child survival on our activities. We're convinced that the Child Survival Program has enhanced CARE's efforts in primary health care in several ways.

First, the manner in which the Child Survival Program is structured has given CARE the opportunity to standardize to a certain degree its approach to health care in these six projects.

The common features which our child survival projects share have allowed CARE the opportunity to develop and test model approaches to oral rehydration therapy and immunization interventions that are useful to us in our other ongoing primary health care projects.

Second, an integral part of the child survival structure is the detailed implementation plan which is submitted to AID Washington during the first year of each child survival project. By positioning the creation of a detailed plan in the project's first year, after funding has been secured, something unusual in overseas development work occurs, something with a tremendous positive impact on the integrity of the community development process and the potential success of these projects.

The detailed implementation plan opens the door for maximum community and counterpart participation in the decision making that goes on in the development of the project.

Third, included in the child survival three guidelines was a list of countries that will remain on the AID Washington child survival eligibility list. Clearly knowing the eligible countries in advance allows for maximum planning during the design phase of child survival projects. CARE sees this as a step forward in the Child Survival Program, and we anticipate that future child survival submissions will benefit from this additional time for project design.

At this point it's difficult to state with statistical accuracy how many lives have been saved because of CARE's involvement in child survival. What is known, however, is that since funds were allocated in 1985 and 1986, CARE's child survival projects have provided wider access to and have promoted the increased use of health services in hundreds of communities and for many thousands of mothers and young children.

Since CARE is not set up as a research oriented institution, CARE depends upon other institutions capable of doing research, such as universities, to gather and analyze quantitative data which reflect impact on the lives of children.

Research oriented institutions have the personnel, time and financial resources to determine more accurately the number of lives congressional funds are saving over a relatively short timeframe.

An example of this is the Johns Hopkins University collaboration with PVO's working on Child Survival Programs in Haiti. Johns Hopkins staff will concentrate on documenting the impact of the Child Survival Program in Haiti in terms of the number of lives saved. CARE, and other PVO's working in Haiti, will be responsible to a greater extent for service delivery and strengthening the local health infrastructure and communities' capacities to carry on in a sustainable manner the child survival activities.

In the 2 years that CARE has participated in the Child Survival Program, we have been able to identify several aspects which need to be addressed in order to make it an even more effective program.

First, funding for each project needs to be available for a longer period of time. In this year's guidelines for child survival proposals, the project period was extended from the original 3 years to 4 years under special circumstances. We welcome this change by AID. We would like to recommend that it be further extended.

In particular, given the nature of our work in child survival overseas, we would like to suggest that the timeframe be extended from 4 years to at least 5 years. The health problems of the community levels that we're dealing with are not susceptible to quick remedies, and a longer timeframe will create a better structure for which to deal with these kinds of programs.

Second, the types of indicators used for reporting project process to AID need to be expanded to adequately reflect the dynamics of local involvement and development. Current Child Survival Program reporting requirements do not fully appreciate the importance and complexity of the community organization phase of the projects, nor provide indicators for it.

Third, CARE has found that the current group of primarily preventive activities highlighted by the twin engines of diarrheal control and immunization, does not retain a lasting interest on the

part of the participating communities if these activities are implemented in a vaccum.

The activities need to relate to an overall development program which also addresses other real needs of the communities.

In particular, although CARE includes health education for women as a key part of its primary health care projects, we would like to devote more attention through child survival to the basic education of women. That way, women would be empowered to make better choices about health.

In most families the women represent the basic actor in all child survival efforts on the family level. In general, family planning activities have not been promoted or supported by the current administration in the Child Survival Program. And, when one considers that a reasonable period of birth spacing is essential to maternal health, and good maternal health is critical to the health and survival of the family unit, it is an unhealthy decision not to support family planning efforts and education actively.

From the point of view of shortages of such resources as trained teachers trained in accessible health providers, and from the microeconomics of the family, family planning should be considered of the highest importance in association with health and nutrition and ultimately with child survival.

Fourth, technical assistance has been a subject widely discussed in connection with the child survival projects. PVO's have considerable internal resources to draw on in this case. In CARE's case, for example, we have primary health care, regional technical advisors, posted in east and west Africa, in Asia and Latin America. These individuals are available to provide technical assistance to CARE's child survival projects in a timely and consistent manner.

In order to supplement this technical assistance and include outside perspectives on CARE's work and health, CARE would like to play a more active role in accessing technical assistance provided through AID of the Child Survival Program.

CARE recommends in an effort to strengthen national capacities to provide technical assistance that AID facilitate the PVO's abilities to work closely when possible with indigenous groups capable of providing appropriate technical assistance.

In short, CARE suggests that the PVO's be given more latitude by AID in addressing their own technical assistance requirements.

All four of the points listed above are related to the underlying element of sustainability of child survival efforts. That is, in order for projects to become sustainable by the communities themselves, one, PVO's must have longer periods of time in which to work; two, project progress must be measured in terms of community organization and development as a prerequisite framework to measuring eventual health impact; three, interventions allowable for child survival must be recognized as integral parts of a dynamic community process, and therefore, should not be implemented in a vaccum; and four, indigenous institutions capable of providing ongoing technical assistance in child survival countries should be encouraged to participate more fully with PVO's at the field level.

Although child survival interventions are low cost, they are not no cost, and thought has to be given to the recurrent cost of these programs and their burden on scarce national budgets.

In conclusion, I would like to thank the Members of Congress, AID, and sister PVO's and field staff who have worked so hard at making the Child Survival Program a mechanism through which improved health for children is becoming a reality in selected countries.

I would also like to extend an invitation to Members of Congress and to their staff to visit CARE projects and other field projects in the field as a way much more effective than the kind of testimony we can give here could ever be of allowing you to see what is actually going on in the field.

Overall, the Child Survival Program is viewed by CARE as being one concrete step toward the commitment made at Alma Ata in 1978 to promote health for all by the year 2000. For this we applaud all those responsible.

Thank you.

Mr. HALL. Thank you.

[The prepared statement of Mr. von Bernuth appears at the conclusion of the hearing, see p. 46.]

Mr. HALL. Mr. Palmer and Dr. Sommer, you both talked about sustaining a level of this program, you talked about continued support. And what you have outlined, what you have in your mind, what you have as far as what you would like to see, not only your institute, but the direction can go, can we continue to have a program that you have talked about with the kind of funding that is being talked about today in Congress?

Mr. PALMER. We anticipate that with the earmark as was earlier designated, that within the next year we would be able to administer vitamin A to 15 million children. Our goal is to reach 65 million children. With a greater allocation of funds I think our ability to move these programs forward would invariably be enhanced.

Dr. SOMMER. I think that the present level of funding has been adequate for now. As we discussed, however, I think the first time this committee talked about the vitamin A initiative, like all initiatives you have to begin to develop a locomotive with the infrastructure in place, develop the will in the local areas, work on evaluating and developing sustainable, culturally appropriate programs.

I think the funding that's been asked for for this year is appropriate to that. But I think if you look toward the long-term, we're looking to 5, 10 years to get this program completely integrated and underway around the world. And with each year, as more countries make the decision that this is something that they recognize is in the best interest of their children's health and their health structure, and wish to come on-line and need the technical assistance and resources to get things underway, and to develop and evaluate these programs, more and more funds will be needed.

I think that's an appropriate way to approach it, rather than to give too much money at the beginning and then cut off a program, is to build up those funds as the program builds. And we're seeing very, very rapid development of interest and activities in the field over this last 2 years.

Mr. PALMER. If I could just highlight that, Mr. Congressman, one of the roles our agency plays is that of a technical assistant to local ministries of health. And we are engaging, as the representative here noted, a systemic change in the developing world, and that is

a long range process and it takes continued support of Congress through agencies such as ours.

Mr. HALL. You describe a program of incredibly high cost-effectiveness, saving a child's sight and his life, as I understand your testimony, can cost less than 1 cent per child. Is that correct?

Mr. PALMER. Yes, sir. We estimate at the present time that the cost of the vitamin A capsule is 1.6 cents per dose, and that with the nutritional services, the delivery system that requires us to carry this service this to the child in the field, the cost is 50 cents per child.

Our goal is, and part of the research operations we are engaged in is, in fact, to reduce the cost to the delivery of vitamin A capsules to the child to less than 1 cent.

Dr. SOMMER. If I can add something, Congressman. One of the beauties of the vitamin A activity is that in essence it might cost almost nothing by the time the full integration is in place.

For one thing, there are many alternatives to the capsule. The capsule has been a short immediate term emergency measure which, as inexpensive as it is, is still a high cost in relationship to other alternative interventions that could have very much the same effect.

I described briefly a supplementation program which was carried out in West Java in which MSG was fortified with vitamin A. In the years to come, Indonesia will insist that all the MSG in the country, which is widely consumed and widely utilized by the target population, will be fortified with vitamin A. This adds a very marginal cost to the MSG, and that will be passed onto the consumer because it's very small, especially in relationship to local inflation, such that the entire program will be self-sustaining locally.

The second major intervention, of course, which is even less expensive eventually is when we get people to feed their children and feed themselves adequate amounts of vitamin A from locally available dietary sources. In most places those dietary sources are in place. It's a matter of educating the people to use them and use them appropriately. Once that is accomplished, it should be essentially no cost to the program.

Mr. HALL. Well, I just find it to be so incredible that it's so very cost-effective and we're starting to see some very staggering statistics relative to infant mortality rates going down, at rates that we thought impossible last year, a year and a half ago, and yet the rates even look better. It's staggering.

I guess I don't understand why the various groups in the world aren't shouting from the rooftops about what seems to be a miracle vitamin.

Dr. SOMMER. Is that a question or a comment?

Mr. HALL. It's more of a statement, really. It's kind of a puzzlement to me. It's so exciting to read and hear about these things.

Dr. SOMMER. Well, I think part of that is that it's so exciting and it was not expected that it has taken a number of people by alarm and by surprise. But I think that a number of people are shouting from the rooftops.

What we have to look at, and I think it's appropriate, that people who live in very different environments, areas of Africa and other areas of Asia, have to see for themselves that within their own par-

ticular meliuer they will see the same sort of impact that's been seen now in Indonesia, now in this measle study in Tanzania, and so forth. And that, of course, is part of the thing that is being funded by the vitamin A earmark.

All the data that's been accumulated to date indicates that we are likely to see very much the same phenomena every place we look. But good scientists are skeptics by nature and a number of programs are already underway to examine this question in a variety of countries. And we're, of course, doing the same thing.

But it is something that is exciting and people as famous as Professor Horowitz opened the International Congress of Nutrition in Brighton using this as an example of we've become complacent in nutrition, and here's old vitamin A, A because it was the first fat soluable vitamin discovered which we thought we knew everything that it did, and low and behold it's doing much more.

WHO has launched a program. I alluded to the UNICEF-WHO position paper on providing vitamin A to children with measles. I think it really is beginning to take hold and in a few years will find people shouting from higher and higher rooftops.

Mr. HALL. I have some other questions I would like to submit to you in writing. Thank you very much for your testimony, both of you.

I'd like to pose a question or two to Mr. von Bernuth. You state that CARE has a primary health care projects in 73 countries, I believe.

Mr. VON BERNUTH. I believe that we have 73 primary health care projects. We work in 38 countries, 39 countries, worldwide. So we have a number of countries; India, Bangladesh, for instance, which may have two or three projects going on in them.

Mr. HALL. And U.S. AID is providing funds to how many?

Mr. VON BERNUTH. Six of those projects, six projects.

Mr. HALL. Are the six all in 1986 or are they carry overs?

Mr. VON BERNUTH. A third of them were originally funded in 1985, two new ones were funded in 1986, so giving a total of six.

Mr. HALL. Has this been a problem for you?

Mr. VON BERNUTH. Are you asking if we could have submitted or used additional funds for more projects? The answer quite clearly is yes. CARE operates worldwide a very substantial set of systems for delivering assistance of all types overseas. That assistance, the infrastructure we have and the personnel we have was sufficient last year to deliver over $350 million worth of assistance.

We would like to be able to deliver much more assistance in the area of health, primary health care. Our current level of support under child survival is in the neighborhood of a little more than $1 million a year from AID. Clearly we have the capacity and the infrastructure to deliver much more assistance were it there.

Mr. HALL. What kind of answers do you get when you approach AID and you put in your contracts and bids for more programs in these various countries?

Mr. VON BERNUTH. Basically we work within a framework in which as the person who testified on behalf of AID earlier indicated, there is a central pooling of projects which we can submit centrally for which this year they've allocated $9 million. So that is, of course, the initial limitation, and those $9 million are then distrib-

uted amongst a number of agencies who compete in a fashion for them.

I think we're in a situation where our understanding is that resources available to us are limited.

Mr. HALL. Are all of the PVO's feeling this way? I know that you can't answer for all of them, but are you all together on this and pushing?

Mr. VON BERNUTH. I certainly would be happy to hear from others at the table, but the PVO's have met collectively to discuss this issue. And it is certainly my belief that they would appreciate further resources.

Mr. HALL. You raised a concern related to technical assistance, and can you give us an example of what you're talking about there? I didn't quite understand that.

Mr. VON BERNUTH. I have a colleague with me here in the room today, and if I could ask them to speak to the issue, who has been dealing with this in the context of the wider group of PVO's and their feelings on the technical assistance issue, a representative of our Washington office, if that is not satisfactory, then I——

Mr. HALL. Why don't you just—if you're not prepared to answer the question, then have him submit it to me.

Mr. VON BERNUTH. Fine.

Mr. HALL. Now, do you have a vitamin A program?

Mr. VON BERNUTH. Yes. We use vitamin A in many of our projects, usually as a component of the multifaceted primary health care project. We distribute vitamin A capsules to small children and to pregnant mothers in some of our projects.

We also encourage home gardening in a number of our projects. In the home gardening projects there is a strong emphasis on vitamin A rich vegetables as a home supplementation of the diet.

Mr. HALL. Maybe one last question for all of you or one of you. How do you balance your program relative to the capsules versus the education versus the agriculture part of growing crops with vitamin A in them?

Is there a program all set out over a number of years to do that?

Mr. PALMER. I think we're still feeling our way, along with Dr. Sommer, who might be able to speak further to this, for example, in Bangladesh, one of our principal country program, we are developing printing materials to educate indigenous personnel in proper nutrition, vegetable gardening, hygiene.

We also in Indonesia are doing social marketing studies and studies that compare vitamin A distribution with capsules and liquid application.

In terms of education, distribution and working with governmental systems through technical assistance are really going concurrently, and certainly the overall strategy is to bring the educational reorganization realization across-the-board in a country where proper nutrition takes care of the vitamin A problem.

Dr. SOMMER. If I could just say a word, we feel our way, but it's mostly looking at what's culturally appropriate. In almost every instance countries have begun with periodic massive dosing because that was the quickest thing to put into place. People assumed that the absence of a balanced vitamin A rich diet was because there was an absence of vitamin A containing foods.

And surveys in many of the countries have now indicated quite surprisingly that most of the children who are short of vitamin A have vitamin A available. For instance, 95 percent of the children in Indonesia who developed xerophthalmia, their families consumed vitamin A rich foods every day. These vitamin A rich foods are in the cooking pot.

The problem is simply moving it from the cooking pot into the child's mouth. So as we discovered this, the whole question of changing the diet becomes much simpler because the food is already there, it's culturally acceptable, and that becomes less of a problem.

Where one can find an appropriate vehicle that can be fortified with vitamin A becomes an automatic delivery system at very low costs. One is only then paying for the vitamin A, and that can be managed rather effectively.

And so, one has to look at what's available in a country and develop a system that is appropriate for that particular institution. But those three represent the general mix beginning with the period massive dose because that's the easiest to put in place to begin with and to treat children who need it on an emergency basis, and then shifting over to fortification and nutrition education as quickly as one can.

Mr. VON BERNUTH. If I might add a comment on that. Talking from a wider spectrum than only vitamin A, CARE's approach toward this situation of what interventions and in what combination relates basically to our approach toward community participation.

We feel that the most effective way is to approach the community with a menu essentially of available activities, any of which and all of which will be beneficial for that community's health situation, and then to work with the community, given their feelings and their capabilities, to prioritize both the order in which such activities would be introduced and the way they would be introduced so that they, in fact, reflect a maximum of community participation in the process.

Mr. HALL. Well, I want to thank you on behalf of the committee for your diligence and your testimony and the work that you're doing in your respective schools and institutes and PVO. We thank you for what you're doing. It's great.

That will conclude this hearing.

[Whereupon, the hearing concluded at 11:40 a.m.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Good morning. I, too, would like to thank our distinguished visitors for appearing before the Select Committee on Hunger today. We are always pleased to hear from the Agency for International Development, UNICEF, and representatives of private voluntary organizations on their roles in promoting development and alleviating hunger and malnutrition in less developed countries. I commend the gentleman from Ohio, Mr. Hall, for convening this meeting of the International Task Force, and look forward to the statements we will hear this morning.

This hearing reflects the continuing strong interest of Members of Congress in general, and Members of the Hunger Committee in particular, on the hope of truly assisting poor and hungry people through foreign aid programs which are well-designed, well-implemented, and which meet the needs that people define for them-

selves. Basic health and nutrition programs, such as oral rehydration, immunizations, and Vitamin A therapy give parents the hope that their children will live and grow, and that they can hope and plan for a better life. This hope is one of the most crucial elements in the development process—the hope that conditions of grinding poverty and frequent hunger can be overcome.

We are aware of budget constraints in foreign aid, and we are interested in cost-effectiveness in foreign aid programs. But most of all we are interested in making sure that our foreign assistance helps to alleviate hunger and improve nutrition of poor people. That's why we are holding this hearing today.

Under the leadership of Tony Hall, this Task Force has been at the forefront of congressional efforts to maintain and enhance efforts in international health and nutrition. Proposals to increase AID's Child Survival Fund, resources for universal child immunization, and funds for Vitamin A programs have all originated from the work of this Task Force, and have all been successfully ushered through the legislative process. We are proud of our involvement in these global efforts, and look forward to hearing from the agencies and organizations carrying out the programs on their progress.

Thank you for your interest and your participation, and I look forward to your statements.

PREPARED STATEMENT OF HON. DOUG BEREUTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Chairman, I want to compliment you for calling this hearing this morning. Today's session is the latest in a series of efforts by this Committee to focus on the problems of inadequate nutrition and poor health in many developing countries around the world.

This Committee met just over a year ago (April 30, 1986) on this same subject. Much work has been done since then, and it is fitting that we receive current information from today's witnesses.

Last year, in addition to Peter McPherson from AID, we heard from Dr. Richard Jolly of UNICEF, and I am pleased to see him back before us again. We also heard from a representative of Helen Keller International, and this morning we welcome John Palmer of that organization. This Committee knows of that organization's important work with respect to health and vision, and, in particular, the importance of Vitamin A.

Almost two years ago, our Committee received testimony that 11,000 children a day die from six infectious diseases. If this number of fatalities resulted from a natural disaster, like an earthquake or a flood, there would be an immediate international relief effort. This number is all the more outrageous when one considers that each one of these diseases causing these 11,000 deaths is preventable. We have made some progress toward immunization of our world's children, but the effort has been relatively slight. There is much more that is needed.

I would also emphasize how inexpensive it is to treat some of our worst health problems. Many vaccines are inexpensive. We know that the greatest cause of death is from dehydration caused by diarrhea. Oral Rehydration Therapy (ORT), which this Committee has studied in detail is not only very effective, it is also very inexpensive.

These are issues which are important to me and to the other Members of the Committee. As the Vice Chairman of the International Task Force, I am pleased that we are looking at this set of problems again and are continuing our study of this matter. I welcome all of our witnesses and look forward to their testimony.

PREPARED STATEMENT OF BRADSHAW LANGMAID, DEPUTY ASSISTANT ADMINISTRATOR, BUREAU FOR SCIENCE AND TECHNOLOGY, AGENCY FOR INTERNATIONAL DEVELOPMENT

This is the third time that this Committee has held hearings on child survival and the third time that a representative of the Agency for International Development (AID) has testified before this Committee on our child survival programs. We appreciate your continued support for this program and welcome your interest in its progress.

Child survival has become one of the Agency's highest priorities. The state of children's health in developing countries has long been of concern to this Agency as part of our health, nutrition and family planning programs. However, since 1985, when Congress established the Child Survival Fund, AID has expanded and focused our efforts on cost-effective programs to save children's lives.

To support its Child Survival program, the Agency has adopted a multi-account strategy, drawing on the Child Survival Fund, the Health Account, and the Economic Support, Sahel and Africa Funds. As a result, the total of all accounts supporting child survival activities has grown from 124 million dollars in Fiscal Year 1985 to approximately 150 million in FY 86 and in FY 87. Despite budget stringencies, we are committed to staying the course and to maintaining this level. The Child Survival Fund itself has grown from the 25 million dollars established by the Congress in Fiscal Year 1985 and has been institutionalized in the Agency's budget. In FY 88, the Administration is requesting 61 million dollars for the Child Survival Fund plus an additional 14 million dollars from the Africa Fund specifically for child survival activities.

AID has revised its Health Policy to give primary emphasis to child survival initiatives. We have put in place a Child Survival Strategy and specific sub-strategies laying out our approach to diarrheal disease control, immunization, nutrition and child spacing. We have identified 22 countries were the needs of children are especially great and are developing country-specific child survival strategies in each of them.

Our goals are ambitious. AID's overall goal is to reduce infant mortality to below 75 for every 1,000 infants born. There is evidence that infant mortality is coming down, but even at 75 deaths per 1,000 births, it is still nearly eight times the rate in the United States. We have set similarly ambitious goals for extending essential child survival services. AID's objectives are to make oral rehydration therapy universally available and to help countries move toward full immunization of at least 80 percent of their children and to sustain that coverage.

Making these goals a reality will require tremendous effort from the countries of the developing world and public and private international agencies. It is truly an international, multi-donor, and multi-agency effort. UNICEF, the World Health Organization, and AID enjoy a close and collaborative working relationship on child survival programs. Private voluntary organizations, including Rotary, CARE, and Save the Children, universities, other donors and many other groups have joined in this historic effort with strong public and private support.

A good start has been made. Today, AID is supporting child survival activities in more than fifty countries in the developing world and investing additional effort in the 22 countries where the needs and the opportunities to assist are especially great. In the past year, alone, AID launched new child survival projects in Egypt, Bangladesh, Morocco, India, Niger, Nigeria, Guatemala, and Yemen, and expanded efforts in Haiti, Ecuador, Malawi, and Zaire among other countries. In addition, we began a major effort in the Americas with four other donors to eradicate polio and strengthen immunization programs in that region and we expanded regional child survival activities in Africa to reach thirteen countries, including Nigeria.

The results we see are particularly gratifying.

In Honduras, there has been a 40 percent decrease in deaths associated with diarrheal disease; over 90 percent of the population is vaccinated against polio and 80 percent against measles, diphtheria, and whooping cough.

In Ecuador, in 1986, immunization of children (12-23 months) rose from 40 percent to nearly 80 percent at a cost of approximately $20 per child. The immunization of infants under one also increased but must receive further attention.

In Zaire, measles immunization has increased an average of 24 percent each year for the past three years; 60 percent of the population has access to child survival services. In 1985 alone, more than 1.6 million children received at least one vaccine.

Turkey delivered 27 million doses of vaccine in a 1986 campaign, thus at least doubling its pre-campaign coverage.

In Indonesia, almost all of the women in a rural district were vaccinated with tetanus toxoid after a survey showed that 20 percent of infant deaths were attributable to neonatal tetanus.

Last year, Egypt's national ORT program increased ORT usage to 65 percent and is credited with saving many thousands of children's lives.

A national ORT program in Bangladesh distributed more than a million packets of oral rehydration salts in 1986, the first year of the AID-sponsored project.

We believe that these kinds of results justify AID's priority for child survival and continued strong Congressional support.

Immunization and Oral Rehydration Therapy (ORT) are the "twin engines" of AID's Child Survival Strategy. Together, these two interventions address the leading preventable causes of infant and child death: measles, tetanus, whooping cough and dehydration associated with diarrheal disease. We estimate that of the fourteen to fifteen million infant and child deaths each year, 3.5 million are due to immunizable diseases and 5.5 million are associated with diarrheal disease.

Because malnutrition is almost always an underlying cause of death, AID's Child Survival Strategy includes focused nutrition interventions to promote the growth of infants and young children, including the protection and promotion of breastfeeding. Finally, birth spacing is important because repeated pregnancies too closely spaced deplete a mother's physical reserves and make it far less likely that she and her infants will thrive or even survive. On average, babies born less than two years after their older sibling are twice as likely to die as babies born after at least a two year interval. Although most of AID's support for birth spacing comes from the Population Account, it is critical to our Child Survival Strategy.

Country-specific problems and priorities ultimately determine the components of each country's child survival program. Thus, for example, where malaria is a major cause of mortality and morbidity, notably in Africa, malaria control and treatment are included.

Delivering these intervention to those who need them the most is never simple. It may be the challenge of keeping vaccines at the proper temperatures in hot climates or teaching a mother to mix oral rehydration salts carefully and use them efffectively. There are substantial problems that must be overcome in countries where distances are great, trained manpower is limited and resources are finite. Our country experience implementing child survival projects has reconfirmed the value of focusing on what is most cost-effective and what can make the greatest difference to the greatest number.

Even as we have success in sight, we must be concerned with how to sustain the gains that are made. Programs launched with enthusiasm, face the day-in, day-out challenge of sustaining the delivery of these essential services and, in an era of contracting budgets, finding the resources to support them.

What can begin as a special initiative must become routine. Training courses must be ongoing. New behaviors must be reinforced. Technologies must be adapted as problems are encountered and new possibilities arise. Government budgets must institutionalize what has been begun.

International experts now estimate that deaths due to vaccine-preventable diseases and dehydration were reduced by one and one half million last year. UNICEF predicts that over eleven million children—more than the entire school age population of New England and the West Coast—could be saved by the year 2000 by the systemmatic, continued applications of these interventions.

The support of this Committee has been vital to this effort. Full success depends on your continued commitment and that of your counterparts overseas, of international organizations and of public and private agencies to this unprecedented alliance for the welfare of children.

Responses to Questions for Bradshaw Langmaid

Questions Submitted by Hon. Tony P. Hall

Question. You stated that 60 percent, or $38 million, of the funds in the Child Survival Fund, is programmed through private voluntary organizations. Please provide to the committee a breakdown of this total by project, country, and agency.

Answer. In both fiscal year 1985 and fiscal year 1986 nongovernmental organizations played an important part in our Child Survival Program and, in both years, received a substantial portion of the Child Survival Fund. In fiscal year 1985, $15.4 million, or 62 percent of the $25 million Child Survival Fund supported the activities of United States and local private voluntary organization both by direct grants from AID and as subgrant supported by an AID-funded grant to UNICEF.

In fiscal year 1986, $24.3 million, or 67 percent of the $36 million Child Survival Fund supported the activities of nongovernmental organizations, including $12.3 million for United States and local PVO's directly and $12 million for UNICEF and PAHO. In fiscal year 1986, a total of $38 million from various accounts supported the health and child survival activities of U.S. PVO's. In fiscal year 1987 we have preliminary data through June 30, 1987 which indicates that $33 million has been programmed for U.S. PVO's. A break-out of these totals is attached as you requested.

SUMMARY TABLE: PVO AND NGO ACTIVITIES IN HEALTH AND CHILD SURVIVAL, FISCAL YEAR 1987 [1]

[In thousands of dollars]

	Total	U.S. PVO's	Non-U.S. NGO/ unidentified
CSF	28,730	12,912	15,818
FN	3,200	3,200	0
HE	33,104	16,980	16,124
ESF	0	0	0
Total	65,034	33,092	31,942

[1] Reported as of June 30, 1987.

[In thousand of dollars]

Country	Title	Project No.	Approp. acct.	Type	Fiscal year 1987
Africa:					
Kenya	Corat/Community Child Survival	6150241	CS	Local PVO	$1,200
Kenya	World Vision/CS Grant		CS	U.S. PVO	470
Mali	World Vision/CS Grant		CS	U.S. PVO	740
Niger	Cara/CS Grant		CS	U.S. PVO	850
Nigeria	ADRA/CS Grant		CS	U.S. PVO	300
Nigeria	UNICEF (ACSI–CCCD Grant)	6980421	CS	NGO	1,500
Sudan	ADRA/CS Grant		CS	U.S. PVO	400
Sudan	Child Survival Project	6500084	CS	NGO/WHO	450
		6500084	CS	NGO/UNICEF	1,550
Uganda	Child Survival Project	6170110	CS	NGO/UNICEF	200
Subtotal					7,660
Asia-Near East:					
Bangladesh	Urban Volunteers	3880073	CS	NGO/ICDDR/B	500
Bangladesh	World Relief/CS Grant		CS	U.S. PVO	450
India	Care/CS Grant		CS	U.S. PVO	800
India	PVOs for Health II	3860511	CS	Local PVOs	3,500
Indonesia	ADRA/CS Grant		CS	U.S. PVO	260
Nepal	Save the Children/CS Grant		CS	U.S. PVO	580
Nepal	Meals for Millions/CS Grant		CS	U.S. PVO	240
Pakistan	Aga Khan/CS Grant		U.S. PVO	770	
Pakistan	ADRA/CS Grant		CS	U.S. PVO	240
Subtotal					7,340
Latin America and the Caribbean:					
Bolivia	PVO ORT/CRS	5110590	CS	U.S. PVO	150
Bolivia	Save the Children/CS Grant		CS	U.S. PVO	700
Bolivia	Meals for Millions/CS Grant		CS	U.S. PVO	460
Bolivia	Andean Health/CS Grant		CS	U.S. PVO	220
Bolivia	CARE/Child Health	5110599	CS	U.S. PVO	1,800
El Salvador	HOPE/Health and Jobs	5190281	CS	U.S. PVO	1,000
El Salvador	Save the Children	5190300	CS	U.S. PVO	932
Guatemala	SAWSO/CS Grant		CS	U.S. PVO	500
Haiti	Mobilizing Mothers/HAC	5210194	CS	Local and U.S. PVO	3,000
Haiti	World Vision/CS Grant		CS	U.S. PVO	400
Haiti	World Relief/CS Grant		CS	U.S. PVO	350
Honduras	Save the Children/CS Grant		CS	U.S. PVO	570
Regional	Accelerated Immunization	5980643	CS	NAO/PAHO	3,148
Subtotal			CS		13,230
Worldwide projects: AID/W Office st/H.	Path/Project Support	936953	CS	U.S. PVO	500
Grand Total					28,730

Note: $28 million or 382 of the fiscal year 1987 Child Survival Fund is supporting PVO and NCO activities including UNICEF and PAHO.

FISCAL YEAR 1987: AID FUNDING FOR HEALTH AND CHILD SURVIVAL U.S PVO-ACTIVITIES

[Dollars in thousands]

Country	Title	Proj. No.	Approp. acct.	PVO	Fiscal year 1987
Africa:					
Comoros	Care (PVO)	6020001	FN	U.S. PVO	$600
Kenya	World Vision/CS Grant		CS	U.S. PVO	470
Mali	World Vision/CS Grant		CS	U.S. PVO	740
Niger	Care/CS Grant		CS	U.S. PVO	850
Nigeria	ADRA/CS Grant		CS	U.S. PVO	300
Sudan	ADRA/CS Grant		CS	U.S. PVO	400
Subtotal					3,360
Asis/Near East:					
Bangladesh	World Relief/CS Grant		CS	U.S. PVO	450
India	Care/CS Grant		CS	U.S. PVO	800
Indonesia	ADRA/CS Grant		CS	U.S. PVO	260
Indonesia	PVO Co-Financing II-OPG/CRS	4970336	HE	U.S. PVO	400
Nepal	Save the Children/CS Grant		CS	U.S. PVO	580
Nepal	Meals for Millions/CS Grant		CS	U.S. PVO	240
Nepal	Save the Children/OPG	3670144	FN	U.S. PVO	100
Pakistan	ADRA/CS Grant		CS	U.S. PVO	240
So. Pacific Reg	PVO Co-Financing-OPG	8790001	HE	U.S. PVO	200
Subtotal					3,270
Latin America and the Carribbean:					
Bolivia	PVO ORT/CRS	5110590	CS	U.S. PVO	150
Bolivia	Save the Children/CS Grant		CS	U.S. PVO	700
Bolivia	Meals for Millions/CS Grant		CS	U.S. PVO	460
Bolivia	Andean Health/CS Grant		CS	U.S. PVO	220
Bolivia	CARE/Child Health	5110599	CS	U.S. PVO	1,800
E. Carib. Reg	Immediate Health Care/HOPE	5380149	HE	U.S. PVO	1,050
El Salvador	Save the Children	5190300	CS	U.S. PVO	932
El Salvador	HOPE/Health and Jobs	5190281	CS	U.S. PVO	1,000
El Salvador	Health and Jobs/HOPE	5190281	HE	U.S. PVO	4,620
Guatemala	SAWSO/CS Grant		CS	U.S. PVO	500
Haiti	World Vision/CS Grant		CS	U.S. PVO	400
Haiti	World Relief/CS Grant		CS	U.S. PVO	350
Haiti	CARE/Community Water	5210155	FN	U.S. PVO	1,800
Honduras	Save the Children/CS Grant		CS	U.S. PVO	570
Subtotal					14,552
Worldwide projects:					
AID/W Office					
FVA	Ocean Freight Reimbursement	9380238	HE	U.S. PVOs	3,000
FVA	Coop for American Relief Everywhere CARE.	9380267	HE	U.S. PVO	1,000
FVA	Helen Keller International (HKI)	9380269	HE	U.S. PVO	600
ST/H	PATH/Project support	9365953	CS	U.S. PVO	500
FVA	International Eye Foundation-OPG.	9380270	HE	U.S. PVO	275
FVA	Adventist Devel. & Relief Agen. (ADRA).	9380273	HE	U.S. PVO	400

FISCAL YEAR 1987: AID FUNDING FOR HEALTH AND CHILD SURVIVAL U.S PVO-ACTIVITIES—Continued

[Dollars in thousands]

Country	Title	Proj. No.	Approp. acct.	PVO	Fiscal year 1987
FVA	AMR Med and Research Foundation (AMREF).	9380276	HE	U.S. PVO	213
FVA	Project Concern International (PCI).	9380282	HE	U.S. PVO	400
FVA	Salvation Army World Service Office (SAWSO).	938XX23	HE	U.S. PVO	472
FVA	World Vision Relief Agency	938XX64	HE	U.S. PVO	650
FVA	Project HOPE	938XX66	HE	U.S. PVO	500
FVA	Meals for Millions/Matching Grant.	9380261	FN	U.S. PVO	700
ST/NUT	Nutrition: Surveys and Surveillance.	9311064	HE	U.S. PVOs	175
ST/H	DIATECH	9365935	HE	U.S. PVO	1,500
ST/H	HEALTHTECH	9365968	HE	U.S. PVO	1,525
Subtotal					11,910
Total					33,092

FISCAL YEAR 1986: AID FUNDING FOR HEALTH AND CHILD SURVIVAL ACTIVITIES OF U.S. PVO'S

[In thousands of dollars]

Country	Title	Proj. No.	Appr.	Implagt. agent	Fiscal Year 1986
AFRICA:					
Cameron	SCF:86 CS Grant	9380524	CS	SCF	$370
Comoros	Care(PVO)	6020001	FN	CARE	750
Kenya	AMREF:86 CS Grant	9380519	CS	AMREF	750
Malawi	SCF:86 CS Grant	9380524	CS	SCF	280
Mali	CARE:86 CS Grant	9380516	CS	CARE	550
Mali	PLAN:86 CS Grant	9380522	CS	PLAN	200
Nigeria	Africare:86 CS Grant	9380517	CS	Africare	440
Senegal	WVRO:86 CS Grant	9380518	CS	WVRO	270
Senegal	CRS:86 CS Grant	9380523	CS	CRS	440
Somalia	PVQ Development Partners Project	6490138	HE	Multiple	4,600
Sudan	Internal Food Aid Transport	6500080	HE	ADRA	515
Sudan	CARE:86 CS Grant	9380516	CS	CARE	750
Sudan	WVRO:86 CS Grant	9380518	CS	WVRO	370
Sudan	SCF:86 *ERR97*CS Grant	9380524	CS	SCF	580
Zaire	Kimbanquist Hospital Assistance	6600122	HE	Hadassah/USA	250
Subtotal					11,615
AF Regional	Vitamin A Deficiency	9310045	FN	Multiple	675
Africa total					12,290
ASIA/NEAR EAST:					
Indonesia	PVO Co-Financing II–OPG	4970336	HE	Multiple (CRS)	400
Napal	PVO Co-Financing OPS	3670144	HE	SCF	
Philippines	PVO Co-Financing II–OPG	4920367	HE	Multiple 1,922	175
So. Pacific Reg.	PVO Co-Financing-OPG	8790001	HE	FSP, SCF, IHAP	200
Thailand	PVO Co-Financing II-OPG	4930342	HE	Multiple	200
Subtotal					2,897
ANE Regional	Vitamin A Deficiency	9310045	FN	Multiple	1,700
Asia/Near East total					4,597
Latin America and Caribbean:					
Belize	Child Survival Technical Support	5050017	HE	HOPE	500

FISCAL YEAR 1986: AID FUNDING FOR HEALTH AND CHILD SURVIVAL ACTIVITIES OF U.S. PVO'S—Continued

[In thousands of dollars]

Country	Title	Proj. No.	Appr.	Implmgt. agent	Fiscal Year 1986
Belize	Village Health Sanitation-OPG	5050024	HE	CARE	200
Belize	Maternal and Child Health	5050032	HE	CARE	250
Bolivia	Water and Health Services	5110599	HE	CARE	1,986
Bolivia	Child Health and Rural Sanitation	5110599	CS	CARE	500
Bolivia	Esperanca:86 Child Survival Funding.	9380520	CS	Esperanca	550
Bolivia	PCI:86 Child Survival Funding	9380521	CS	PCI	500
Bolivia	PLAN:86 Child Survival Funding	9380522	CS	PLAN	500
E. Carib. Reg.	Immediate Health Care	5380149	HE	HOPE	550
Equador	Strengthening Community Organization.	5180033	HE	SCF	155
Equador	Private Sector Health Delivery Model (OPG).	5180060	HE	MAP Inter	245
El Salvador	Hlth. and Jobs for Displaced Families OPG.	5190281	HE	HOPE	3,000
Guatemala	PCI:86 Child Survival Funding	9380521	CS	PCI	400
Haiti	Mobilizing Mothers for Child Survival.	5210194	CS	Multiple	2,400
Peru	Expanded Funding Program	5270247	HE	ADRA	175
Peru	Expanded Feeding Program	5270247	FN	ADRA	400
Peru	Expanded Improved Feeding Program.	5270248	FN	CARITAS	150
Peru	Caritas Feeding Program	5270248	HE	CARITAS	125
Peru	Food for Work	5270261	HE	CARE	125
Peru	Food for Work	5270261	FN	CARE	125
Peru	Peruvian PVO Health Promotion Network.	5270294	HE	Seton Inst.	300
Peru	Nutrition for Child Survival Program.	5270297	HE	CARE	42
Subtotal					13,228
LA Regional	Vitamin A Deficiency	9310045	FN	Multiple	450
Latin America and the Caribbean total.					13,678
Global projects:					
AFR Regional					
FVA	Child Survival Tech. Assistance for Africa.	938xxxx	CS	Multiple	200
FVA	CRS Matching Grant: Water	9380135	HE	CRS	425
FVA	Project Concern International	9380193	HE	PCI	150
FVA	World Vision Relief—OPG	9380202	FN	WVRO	850
FVA	Salvation Army World Service Office—OPG.	9380249	HE	SAWSO	500
FVA	Project Hope—OPG	9380252	HE	HOPE	500
FVA	CARE	9380267	HE	CARE	1,485
FVA	Helen Keller International (HKI)	9380269	HE	IEF	275
FVA	International Eye Foundation—OPG.	9380270	HE	IEF	275
FVA	Adventist Devel. & Relief Agen. (ADRA).	9380273	HE	ADRA	400
FVA	AMR Med and Research Foundation (AMREF).	9380276	HE	AMREF	200
FVA	Project Concern International (PCI).	9380282	HE	PCI	400
FVA	Adventist Development Relief Agency.	9380508	CS	ADRA	40
LA Regional	CS Technical Assistance for LAC	938xxx1	CS	Multiple	150
ST/NUT	Nutrition: Surveys and Surveillance	9311064	HE	Multiple	525

FISCAL YEAR 1986: AID FUNDING FOR HEALTH AND CHILD SURVIVAL ACTIVITIES OF U.S. PVO'S—Continued

[In thousands of dollars]

Country	Title	Proj. No.	Appr.	Implagt. agent	Fiscal Year 1986
ST/H	DIATECH	9365935	CS/HE	PATH	1,500
Subtotal					8,200
Global	Vitamin A Deficiency	9310045	FN	Multiple	25
Global total					8,225
Grand total					38,790

Source: AID Health Information System—ISTI.

Question. The Child Survival Report to Congress for fiscal year 1986 states that $150.224 is available for child survival programs. It details $36.425 million in projects. Please provide the committee with a breakdown of the $113 million additional funds which is available for child survival programs through the Economic Support Funds, the Sahel Fund, and the Health Account.

Answer. The breakdown of the full $150 million for child survival activities in 1986 is attached.

FISCAL YEAR 1986 CHILD SURVIVAL ACTION PROGRAM

Country	Project title	Project No.	Total fiscal year 1986 child survival [1] (thousands)	Funding accounts [2]					
				CS	HE	FN	ES	SH	PN
Africa:									
Comoros	Care (PVO)	6020001	750			750			
Kenya	Family Planning Support and Services	6150232	99		99				
Liberia	Primary Health Care Project	6690165	903		903				
Mali	Integrated Family Health Services	6880227	900					900	
Niger	Rural Health Improvement	6830208	360					360	
Niger	Niger Health Sector Support	6830254	1,490					1,490	
Regional	Africa Child Survival Initiative—CCCD	6980421	4,000	4,000					
Regional	Strengthening Health Delivery Systems	6980398	250		250				
Regional	Africa Child Survival Initiative—CCCD	6980421	11,491	11,491					
Somalia	PVO Development Partners Project	6490138	4,600		4,600				
Sudan	Internal Food Aid Transport	6500080	515	515					
Uganda	Dral Rehydration Therapy	6170107	550		550				
Zaire	Basic Rural Health II	6600107	750		750				
Subtotal			26,658	4,000	19,158	750		2,750	
Asia-Near East:									
Bangladesh	Urban Volunteer Program	3880073	3,400	2,000	1,400				
Egypt	Child Survival	2630203	13,620				13,620		
India	Child Survival Support	3860504	15,840	6,000	9,840				
India	Biomedical Research Support	3860492	363		363				
Indonesia	Health Training Research and Development	4970273	3,000		3,000				
Indonesia	Village FP/Mother-Child Welfare	4970305	4,000		4,000				
Jordan	Training in Child Survival & Prim. Hlth. Care	2780270	1,000				1,000		
Morocco	Nationwide Neonatal Tetanus Imm. Support	6080171	2,000	2,000					
Nepal	Integrated Rural Health/FP Services	3670135	116		116				
Pakistan	Primary Health Care	3910475	1,430		1,430				
Philippines	PVO Co-Financing II—OPG	4920367	1,922		1,922				
Philippines	Primary Health Care Financing	4920371	219		219				
Thailand	Science & Technology for Development	4930340	150		150				
Yemen	Child Survival	2790082	2,875		2,875				
Subtotal			49,935	10,000	25,315		14,620		

Latin America and the Caribbean:							
Belize	Child Survival Technical Support	5050017	300		300		
Belize	Breastfeeding Outreach	5050029	12		12		
Belize	Maternal and Child Health	5050032	213		213		
Bolivia	Child Health and Rural Sanitation	5110599	1,652	500	1,152		
Bolivia	Self-Financing Primary Health Care	5110569	49		49		
Bolivia	PVO ORT and Child Growth Monitoring	5110590	42		42		
CA Regional	Regional Child Survival/Immunization	5970005	5,132	2,500	2,632		
CA Regional	Essential Drugs and Malaria	5970007	272		272		
E. Carib. Reg.	Immediate Health Care	5380149	55		55		
Ecuador	Strengthening Community Organization	5180033	62		62		
Ecuador	Malaria Control Project	5180049	675		675		
Ecuador	Private Sector Health Delivery Model (OPG)	5180060	37		37		
El Salvador	Hlth. and Jobs for Displaced Families—OPG	5190281	3,000		3,000		
El Salvador	Health Systems Mgt. Improvement	5190308	6,705		6,705		
El Salvador	Maternal/Child Health Promotion	5190329	220		220		
Guatemala	Immunization/ORS for Child Survival	5200339	6,304	1,600	4,704		
Haiti	Mobilizing Mothers for Child Survival	5210194	2,400	2,400			
Haiti	Rural Health Delivery System	5210091	966		966		
Haiti	Management of Malaria	5210143	48		48		
Haiti	Rural Health and Community Devel. II—OPG	5210159	604		604		
Honduras	Health Sector I	5220153	903		672		231
Jamaica	Health Management Improvement	5320064	80		80		
Peru	Expanded Feeding Program	5270247	564		172	392	
Peru	Expanded Improved Feeding Program	5270248	248		113	135	
Peru	Food for Work	5270261	300		125	175	
Peru	Program Development and Support	5270000	92		92		
Peru	Expanded Reforestation Program	5270231	68		68		
Peru	Peruvian PVO Health Promotion Network	5370294	300		300		
Peru	Nutrition for Child Survival Program	5270297	34		34		
Peru	Private Sector Nutrition for CS	5270308	781		781		
Peru	Training Physicians and Nurses	5270309	150		150		
Peru	Reduction in Child Mortality	5270311	251		251		
Regional	Accelerated Immunization	5980643	500	500			
Regional	Intercountry Technology Transfer	5980616	1,435		1,435		
ROCAP	Food Assistance Support	5960116	2,350		2,350		
Subtotal			36,804	7,500	28,371	702	231

FISCAL YEAR 1986 CHILD SURVIVAL ACTION PROGRAM—Continued

Country	Project title	Project No.	Total fiscal year 1986 child survival [1] (thousands)	Funding accounts [2]					
				CS	HE	FN	ES	SH	PN
Centrally funded global projects:									
FVA	Technical Support/Child Survival	9380500	40	40					
FVA	Adventist Development Relief Agency	9380508	40	40					
FVA	CARE:86 Child Survival	9380516	1,300	1,300					
FVA	Africare:86 Child Survival	9380517	440	440					
FVA	HVRO:86 Child Survival	9380518	680	680					
FVA	AMREF:86 Child Survival	9380519	750	750					
FVA	Esperanca:86 Child Survival	9380520	550	550					
FVA	PCI:86 Child Survival	9380521	900	900					
FVA	PLAN:86 Child Survival	9380522	700	700					
FVA	CRS:86 Child Survival	9380523	440	440					
FVA	SCF:86 Child Survival	9380524	1,270	1,270					
FVA	PVO Child Survival Operations Program	9380526	190	190					
ST/H	HEALRTHCOM	9311018	1,690	1,500	190				
ST/H	Technology for Prim. Health Care	9365927	6,270	2,700	3,570				
ST/H	Diar. Disease Research (ICDDR/B,HHO)	9365928	4,600	1,050	3,550				
ST/H	DIATECH	9365935	1,188	875	313				
ST/H	CSAP Support	9365951	1,567	550	1,017				
ST/H	Applied Diarr. Disease Research	9365952	1,500	950	550				
ST/H	Family Health and Demographic Surveys	9363023	85		85				
ST/H	Health Development Planning & Management	9365901	25		25				
ST/H	Operations Research in PHC (PRICOR)	9365920	1,200		1,200				
ST/H	MEDEX Support	9365932	100		100				
ST/H	ORT—Help	9365939	1,100		1,100				
ST/H	Pediatric Clinic diarrheal Dis. Research	9365940	800		800				
ST/H	Milwaukee Intl. Health Training Center	9365958	213		213				
ST/NUT	Nutrition: Vitamin A Deficiency	9310045	5,430			5,430			
ST/NUT	Nutrition: Iron Deficiency Program Support	9310227	200		200				
ST/NUT	Improvement of Maternal/Infant Diet	9311010	950		950				
ST/NUT	Nutrition: Surveys and Surveillance	9311064	525		525				
ST/NUT	Integration of Health & Nutrition Services	9311198	325		325				
ST/NUT	CSAP-Support: John Hopkins U	9365951	450		450				
ST/RUR	HBCU:86 Grant to Tuskegee Univ	9365053	877		786	91			

ST/RUR	Joint Health MOUs	9365057	364		364				
Subtotal			36,759	14,925	16,313	5,521			
Total			150,156	36,425	89,157	6,973	14,620	2,750	231

[1] Funding for child survival represents only that portion of project funding that supports child survival activities. Total project funding may be higher.
[2] Funding accounts: CS—Child Survival, HE—Health, FN—Nutrition, ES—Economic Support, SH—Sahel, PN—Population.

Source: AID Health Information System—ISTI.

PREPARED STATEMENT OF RICHARD JOLLY, DEPUTY EXECUTIVE DIRECTOR, UNITED NATIONS CHILDREN'S FUND [UNICEF]

Mr. Chairman, Members of the Select Committee: Thank you for the opportunity to appear before the Select Committee once again to discuss the continuing progress of the Child Survival and Development Revolution and UNICEF's contribution toward bringing the benefits of this revolution to the world's most vulnerable citizens.

Two weeks after the annual session of UNICEF's Executive Board, I feel particularly energized to comment on our child survival programmes. Our Board of 41 Member States of the United Nations has been instrumental over these past four years in helping UNICEF generate and maintain the momentum necessary to ensure world-wide success and participation in what is an extremely focused and concentrated programme. The Board has committed us to the ambitious but possible goals for 1990 of Universal Child Immunization (UCI) and expanded knowledge, access and use of Oral Rehydration Therapy, as well as Health For All by the year 2000, and it consistently provides as the wise counsel, guidance and direction necessary to make the most effective and efficient contribution to these goals.

At the conclusion of its two-week meeting, the Board unanimously adopted a resolution which stands as a powerful endorsement of what we have accomplished—and by "we" I mean not only UNICEF, but the vast array of agencies, organizations and individuals, not least among which is the U.S. Agency for International Development, as well as the scores of developing country governments with which we work. More importantly, the resolution constitutes our marching orders for the years ahead. It declares that UNICEF should [inter alia]:

—Work towards retention of the child and its needs on the political agenda;

—Work towards further strengthening the capacities of countries to define the strategy and to implement child survival and development activities;

—Continue the work of child survival and development in both rural and urban areas as a priority, taking into account the specific situation and conditions in each country. It should aim to achieve the goal of reducing infant and child death rates by half by the year 2000, through the achievement of universal child immunization and oral rehydration therapy targets by 1990, through diarrhea management, and through further strengthening support to the promotion of breast-feeding, improved infant and child nutrition and growth promotion, health education and basic education for mothers, and family planning, as well as to other complementary activities such as the promotion of maternal health and pregnancy monitoring, maternal nutrition, the control of respiratory infections and malaria control.

Mr. Chairman, I would like to use my time to outline very briefly the context in which the Child Survival and Development Revolution was launched, and to comment on its accomplishments in human terms, the development lessons learned, and on our future course.

FROM DARK TIMES, NEW HOPE

The Child Survival and Development Revolution is the product of, on the one hand, the acceptance of harsh economic realities, and the seizing of new-found opportunities on the other. The economic scene in the 1980s has been extremely bleak for the vast majority of developing countries, but especially those in Africa and Latin America. 1986 was the seventh consecutive year in which the average growth rate of per capita income in developing countries has been negative or negligible. In 1985–86, at least 50 developing countries—about 70 per cent of those for which we have data—were substantially worse off in terms of average per capita income than they were six or seven years earlier. In almost all these countries, the situation of children has suffered as family incomes continued to decline. Increasing food prices have aggravated the nutritional status of children in the poorest households. The combined effect of declining government expenditure in the social sector and the scarcity of foreign exchange has severely hampered the maintenance and extension of services in health, education, drinking water and sanitation, housing and other areas. The shortage of foreign exchange has reduced the availability of imported goods, including food, basic drugs, water-pumps, teaching materials, kerosene, paraffin, petrol and spare parts. The implementation rate of programmes supported by external assistance has substantially fallen in those countries that lack national counterpart funds.

There is documented evidence that malnutrition has increased and educational levels deteriorated in the 1980s in at least 16 countries in Africa south of the Sahara, 8 in Latin America and 3 in the Middle East and North Africa.

This is the bad news—hard evidence of increasing economic difficulty and decline in much of Africa and Latin America, crying out for national and international action to tackle debt, commodity prices and increased aid and other financial flows.

But there is also a more hopeful side. The early 1980s also heralded:

—Increased understanding of the negative synergism between malnutrition and infection, and the realization that some two-thirds of young child malnutrition is associated with infection or lack of parental knowledge regarding proper nutrition and feeding practices;

—A new awareness in epidemiology that most infant and child deaths stem from a limited number of causes and that certain direct low-cost interventions can significantly improve the health of children with a consequent reduction of the infant mortality rate (IMR) and child death rate (CDR), even in the face of economic difficulties in many countries;

—A series of improved, new or rediscovered low-cost health technologies with mass applicability, e.g. oral rehydration therapy (ORT) and more heat-stable vaccines that can better tolerate occasional cold-chain failure;

—Recognition that many of these interventions (such as ORT and sanitation) can be applied at home and are for family use; indeed, personal behaviour such as washing hands and using latrines is critical;

—Recognition of the significant and greatly under-used capacity to communicate which now exists in virtually all developing countries as a result of the economic and technological progress of recent decades;

—The increasing availability of community-level health and other workers in the expanding PHC systems.

These factors, reinforced by the urgency of cost-effectiveness at a time of global economic constraints, led UNICEF in 1983 and 1984 to adopt a priority programme and set of goals to promote, in as many countries as possible, low-cost interventions for child survival and health, with the aim of "going to scale"—that is, reaching universal coverage. We sought, through this strategy, to give life to the promise of Primary Health Care—by concentrating our efforts on practical action in key areas which would then be extended into other areas.

We initiated a new approach to action—and approach premised on securing high-level political commitment to mobilize the instinctively responsive involvement of a broad array of social forces, including religious, women's, youth, professional and other groups, media (television, radio, print, etc.), national and sub-national authorities, and communities. And we bet that these forces, armed with the low-cost technologies and mass communications techniques I just mentioned, could start a revolution in child survival and development—dramatically reducing infant and child deaths in virtually every developing country.

That new approach, Mr. Chairman, has paid off. The Child Survival and Development Revolution (CSDR) is working.

REVOLUTIONARY PROGRESS FOR CHILDREN

The accomplishments of the CSDR, now in its fifth year, are indeed dramatic. the lives of over four million children have been saved in these five years. The health of tens of millions more has been significantly improved. The promotion of immunization and oral rehydration—the leading edges of this revolution—alone saved the lives of an estimated 1.5 million children in 1986. Today's low-cost methods provide the capacity to save the lives of more than seven million children—every year. We are well on our way—though success is still far from guaranteed—toward the United Nations goals of Universal Child Immunization (UCI) by the year 1990, and just last week the World Health Assembly formally embraced the ORT goals of universal access to and 50 percent use by 1990—a goal which was first proposed by USAID Administrator Peter McPherson at the conclusion of the historic second International Conference on Oral Rehydration Therapy (ICORT II) here in Washington in December 1986.

The record of this progress, Mr. Chairman is documented in a report which we submitted to UNICEF's Executive Board, entitled Progress Review of Child Survival and Development Revolution (1983-1986), a copy of which I would like to submit for the Committee's record. I would like to cite just a few examples of recent child survival accelerations in developing countries, which, I should emphasize, are truly successful only when they provide a base for broadening institutional commitments to child wellbeing, beyond just survival.

In Brazil, President Sarney has announced a new initiative of national mobilization against the poverty that affects millions of Brazilian children. The "CSDR Child First Programme" was launched with a Brazilian Government allocation of

2.5 billion cruzados (about $182 million). The programme aims at assisting street children by offering them employment and schooling, with the support of private enterprise. The Presidential decree, among many provisions, instituted basic education and school lunches for 30 million children (7 to 14 years old) by 1988 and established a four-year time-frame for meeting the school nutrition and health needs of all Brazilian children.

Despite many difficulties, Africa has not only made significant progress in the area of child survival, but CSD actions in several countries have led to the establishment or strengthening of the primary health care systems. A typical example is that of the Congo where President Sassou Nguesso has reorganized the national health system to give more importance to PHC with emphasis on four major components: essential drugs, the expanded programme of immunization (EPI), improved sanitation and nutrition. He also pledged his nation to the goal of raising the current vaccination coverage from 40 to 80 percent by 1990. Cameroon, Morocco and Senegal launched major accelerated immunization programmes designed to more than double immunization levels and reach the 75 percent target during 1987.

In Indonesia, despite severe financial and budgetary constraints caused by falling oil prices, President Soeharto has accelerated EPI programmes and the establishment of posyandus (village-level integrated with health posts) for every 100 children under the age of five. the posyandus promote growth monitoring, ORT, immunization, birth spacing and pre-natal care. The goal is to provide access to more than 85 percent of the nation's children under five years old—approximately 18.1 million—and 4.2 million mothers by the end of March 1988. The President further announced that the posyandu programme would serve as the basis of the strategy for reaching the goals of the "Decade for Indonesian Children" (1986–1996), i.e., to accelerate CSD and to reduce the infant mortality rate.

One feature of the Indonesian effort is a poster showing President and Mrs. Soeharto administering a vaccine. Some 350,000 copies of this poster were distributed throughout the country, and this technique has been replicated in many other countries. This is but one example of the great attention paid to child survival and development by national leaders, decision makers, and opinion makers. While one might see this as mere "publicity, this top-level visibility serves an essential secondary purpose: it underscores to sometimes sluggish bureaucracies that the national leadership is committed and determined to advance the programme. Clearly, the child is now higher on the political agenda of the state in many countries.

Last month, UNICEF's Executive Board accorded our highest honour, the Maurice Pate Memorial Award [named for UNICEF's first Executive Director] to the Catholic Church in El Salvador, on behalf of all the Salvadoran people who have joined together in the past three years, despite their political differences, to protect their children from the greatest danger—disease. Through the dedicated efforts of the Church, as well as many organizations and institutions, and with the support of both the Government and the rebel forces, El Salvador last month observed its ninth "Day of Tranquillity", allowing the National Vaccination Campaign to reach all the country's children. Since its initiation in February 1985, the immunization programme has saved the lives or prevented the crippling of more than 10,000 Salvadoran children. The immunization rate has risen from 50 to 80 percent. The El Salvador programme has led to an unprecedented Central America "Bridge to Peace" initiative with all seven countries and their Heads of State participating last month in a multi-national immunization day.

Mr. Chairman, over 80 countries have now undertaken accelerated immunization programmes, and are now doing their best to achieve our common goal of Universal Child Immunization by 1990.

ADJUSTMENT WITH A HUMAN FACE

The Child Survival Revolution's focus on low-cost approaches is, in many ways, but one manifestation of UNICEF's advocacy of "adjustment with a human face". This economic approach urges greater attention to human needs and protection of vulnerable groups in the national process of economic adjustment in response to the "dark times" of the 1980s. This principle also recognizes that the social sectors themselves need to adjust to become more effective and efficient. the urgency of increased attention to human needs in the course of adjustment has been gaining wider acceptance among many international institutions, notably including the World Bank and the International Monetary Fund, the World Health Organization, and the International Fund for Agricultural Development. [UNICEF and the World Bank, with assistance from the Overseas Development Council and the United

States Committee for UNICEF, will co-sponsor a seminar on Capitol Hill on June 18th to discuss the issues of "adjustment with a human face".]

A NEW TOOL FOR DEVELOPMENT

The Child Survival strategy has also released a major new source of political and social energy in support of measures for children as a whole, from both the highest levels of national leadership and the general public. Knowledge of an encouragement to use the low-cost techniques for child survival has been communicated on national scales through "social mobilization" and mass communications. This experience will be applicable and invaluable in promoting other child-focused and people-focused measures in the future. The coming era is likely to see the application of social mobilization techniques to education, especially basic education, including literacy for women, and in sanitation. Progress in both of these areas will, of course, contribute toward further strengthening and consolidation of CSD achievements. But perhaps more dramatically, we will see social mobilization put to use as the world's first line of defense against AIDS. You are well aware, of course, that the only known means of preventing the spread of HIV infection is education, and this country, like many others, is grappling with the issues of how to educate and motivate people to prevent the spread of AIDS. This challenge occurs on a global scale, as well. Recognizing this, UNICEF's Executive Board also committed us to the battle—not only by reminding UNICEF to take every necessary measure to ensure that nothing we do, such as immunization programmes, contributes to the spread of HIV infection, but also by contributing our considerable knowledge and experience in social mobilization and communications to the broadscale educational effort now needed in virtually every country to contain and reduce this terrible threat to health and survival.

PARTNERSHIPS FOR A BETTER WORLD

Another major outcome of the strategy to accelerate CSD has been the broadening of meaningful international cooperation for children. Little of what has been accomplished in these past few years would have been possible without the invaluable work of several United Nations organizations, including the World Health Organization (WHO), the United Nations Development Programme (UNDP), and the World Bank. In addition to the United States, the bilateral assistance agencies of many countries, including Australia, Canada, Denmark, Finland, France, Italy, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom, and the aid agency of the European Economic Community, all play critical roles. We have also the "coming of age" as major participants in the development process of thousands of international and national voluntary organizations and associations, including, on the global level, the International Paediatric Association, the World Federation of the Public Health Associations, the International League of Red Cross and Red Crescent Societies and Rotary International.

The joint presence here today of senior officers of UNICEF and USAID is merely a reflection of the close collaboration between our two agencies, which many throughout the world would regard as the leading international allies for child survival. Peter McPherson's personal commitment to child survival and ORT has touched many at UNICEF. At the latest in a semi-annual series of meetings of our two senior staffs, Mr. McPherson last week presented twin train engineer's caps to UNICEF Executive Director James Grant and Acting AID Administrator Jay Morris, symbolizing their responsibilities for what we have called the "twin engines" of child survival—immunization and ORT. UNICEF wishes Peter McPherson well in his new responsibilities at the Treasury Department—and, of course, we count on his continuing attention to the needs of children and the most vulnerable!

May I, Mr. Chairman, commend to the Members of the Select Committee AID's recent Second Report to the Congress on Child Survival. UNICEF finds this an excellent review of progress, problems, and prospects, with extremely useful analysis. We made a point of distributing this Report to the Members of UNICEF's Executive Board, and to all UNICEF field offices, and I commend Brad Langmaid for spearheading not only the Report itself, but the Child Survival Action Programme which it represents.

It was this Committee that initiated the significant increases in funding for child survival which the United States Congress has committed, both through the health activities of the Agency for International Development and in the establishment and expansion of the Child Survival Fund. The example which you set, I am very pleased to report, has been emulated by several other governments. The Government of Italy has committed $130 million to support multi-year child survival pro-

grammes in 26 African and 7 Central American countries; the Government of Canada established its "Commonwealth Fund" and "Special Fund for Francophone countries" in Africa in support of UCI, both bilaterally and through UNICEF; and the United Kingdom, Sweden and the EEC have offered substantial additional contributions to UNICEF for these purposes.

Mr. Chairman, with increasing commitment by most developing countries to accelerated child survival measures, we are increasing our attention to the critical issues of the sustainability of gains in mortality and morbidity reduction and to the linkages among child survival, protection and development approaches.

Malnutrition in developing countries is usually the result both of inadequacies of food intake and ill health. Action to improve nutrition must therefore involve efforts on both fronts, as far as possible integrated and mutually reinforcing. Unfortunately, this is too rarely emphasized in media reporting on famine or drought or even in the everyday messages of development agencies. Yet it is vital if we are to make progress in this most fundamental area of basic human needs.

The CSDR has from the beginning incorporated attention to breastfeeding, better weaning and food supplementation—along with the "health" action of ORT and immunization—and growth promotion as the integrating goal for young children and growth monitoring to ensure that it is happening.

Over the last year or two, we have, in addition, been working to strengthen these food related elements:

—by supporting, especially in Africa, actions directed to strengthening household food security, usually focused on support for women and household food production;

—by strengthening collaboration with other agencies working in these areas, especially WFP, IFAD, FAO and specialist institutions such as IITA; we have issued a joint report with WFP, "Food Aid and the Well-being of Children".

More recently, we have embarked on a major initiative with WHO and FAO focused on strengthening nutrition surveillance in developing countries. This joint project is designed to make available basic data on nutritional status within a year or two—internationally and nationally in some 40 to 60 countries of the Third World. To have this data available regularly and up-to-date would be a major step forward in strengthening national and international attention to nutritional matters and in developing meaningful quantitative goals for its reduction of severe malnutrition and its eventual eradication.

Basic education and female education, in particular, are especially important in connection with this broader view, as is the linkage being developed between long-standing water supply and sanitation activities and health education and personal hygiene at the community and family levels. UNICEF will also, of course, continue to be heavily involved with child health and nutrition concerns which go well beyond survival issues. Control of iodine deficiency disorders, alleviation of micronutrient deficiencies such as vitamin A and iron, parasite control and broader questions of household food security are subjects of increasing emphasis in numerous countries.

PROGRESS SUSTAINED

The Child Survival and Development Revolution has already accomplished a great deal in human terms. It has taught us many lessons which will be invaluable in the years ahead, not only for child survival, but for a broad range of development challenges. In many countries, it has brought to a halt the slippage in progress for children which would otherwise characterize the decade of the 1980s, and it is thus proving that forward momentum for people can be sustained even in the most difficult of times, if only society will correctly order its priorities. And no priority should be greater than children.

The continued support and encouragement of the United States Government and its agencies, in which this Committee and the Congress have played so vital a role, will surely determine whether we actually achieve our great goals for 1990 and beyond, and whether humanity's most precious resource—children—receive the protection they so urgently need in their earliest years. This Committee has recognized the value of that early investment; I know that you will continue to do so in the years ahead.

PREPARED STATEMENT OF JOHN M. PALMER III, EXECUTIVE DIRECTOR, HELEN KELLER INTERNATIONAL

Every one of us here has a particular anxiety about the devastating consequences of malnutrition and a plan for help. As executive director of Helen Keller Interna-

tional, my special concern is that millions of children in over 50 nations lack a simple but essential nutrient, vitamin A. This renders them 12 times more susceptible to fatal infectious diseases than non-vitamin-A-deficient children in otherwise similar straitened circumstances. At the very least, it impairs their vision, leaving many permanently blind.

Two years ago, Congressman Leland, you brought the urgent matter of vitamin A deficiency to the American people. You had seen at first hand its tragic consequences on children of the African drought. You were alert to new research linking vitamin A deficiency with child mortality in Asia. And you dubbed the cure—a megadose capsule of vitamin A that costs less than two cents—a "golden bullet." It was this Select Committee, led by Representatives Leland and Hall, that convinced Congress to vote the three-year $24 million vitamin A earmark beginning FY '86 that established vitamin A as an important strategy in our nation's Campaign for Child Survival.

I shall devote my testimony to outlining the advances made possible in the past two years by U.S. funds for vitamin A and Child Survival and to demonstrating the immediate, still urgent need to secure the third tier of the pledged vitamin A earmark in 1988. Though I speak primarily for HKI, be assured that we are not alone. Distinguished universities led by Johns Hopkins, private voluntary organizations here including CARE and Save the Children, agencies within the United Nations—the World Health Organization, the Food and Agricultural Organization, UNICEF—have joined forces to save sight and life. Hoffmann-La Roche spurred the private sector, and many other corporations and foundations support our efforts to match AID grants. Tens of thousands of American citizens are donating money to protect the world's most vulnerable children from the devestating effects of vitamin A deficiency. More and more governments in developing countries are requesting technical assistance.

This current attention to vitamin A has allowed HKI to step up ongoing programs and start many new ones. For example, in Bangladesh and Indonesia, where there are approximately 40 million children at risk, HKI has expanded on existing programs enormously. At this very moment, 27,000 health workers in Bangladesh are being trained with HKI materials to prevent, detect, and treat vitamin A deficiency, and a nationwide awareness campaign is under way. In both countries, vitamin A supplementation is being tried in tandem with other Child Survival strategies, like immunization. Studies are determining if vitamin A supplements can be delivered at a even less than a penny. A newly installed, computerized surveillance scheme will serve ultimately as a model for international vitamin A information management systems. And there is now a very strong emphasis on long-term, self-sustaining solutions to vitamin A requirements with industrial fortification of inexpensive, commonly used foodstuffs, and social marketing to effect behavior change—longer breast-feeding and consumption of vitamin A-rich vegetables. Equally important, policymakers are being educated about the significance of vitamin A deficiency and how to overcome it. With funds currently earmarked, these activities are in full swing, and we can, for the first time, realistically aim to bring them all up to national scale. Further, the Philippines is now receiving intensive vitamin A programming, and, closer to home, Haiti has been added. Nepal is also on the list.

Africa has assumed highest priority. Emergency vitamin A activities begun during the East Africa famine continue unabated, and new programs have begun in Niger, Mauritania, Burkina Faso, and Malawi, where our research shows alarmingly high rates of vitamin A deficiency. To achieve rapid coverage throughout, HKI is providing technical assistance for eight other American private voluntary agencies with Child Survival programs in Cameroon, Kenya, and Malawi, Mali, Niger, and Senegal. The children of Africa are in desperate need of this effective, inexpensive intervention.

In sum, we calculate that approximately 15 million children living in HKI project areas will be reached directly this year. Many more will be covered by other agencies, and by HKI's training materials, which are in use throughout Asia and Africa and in most Central and South American countries.

In 1987–1988, under support of the second year of the vitamin A earmark, HKI expects to increase the vitamin A intake of still larger numbers of children at risk in a way that ensures that all interventions are fully field-tested, evaluated, and documented in a range of cultural and geographic settings. Still more attention will be given to the long-term solutions that will ultimately solve the vitamin A problem. This body of experience, combined with HKI's separately financed vitamin A research, will serve to reach 65 million children in the third year of the earmark. And it will be the basis for disseminating to the public health community a series of practical and immediate strategies that can be replicated on a global scale. As pro-

grams take hold in Africa, HKI will be able to effect national commitments on that continent to the eradication of vitamin A deficiency.

A third year vitamin A earmark will assure AID co-financing that is absolutely essential if these key activities are to go forward successfully and their cumulative effect become apparent. It is key also to the major dissemination efforts that will carry vitamin A deficiency prevention methods and materials to public health officials around the world. It is vital if we are to accomplish in Africa what we will have done in Asia. It is essential if we are to save the target population of 65 million children from sight-threatening, life-threatening tragedies that accompany vitamin A deficiency.

In providing funds designated for vitamin A activities, Congress is making a distinct contribution to Child Survival and sending signals to the world that this American initiative will be completed. American scientists are still researching the essential role of vitamin A on the well-being of children during their most vulnerable years; American technology is hastening the long-term solutions to vitamin A deficiency; and American voluntary agencies are filling the breach with a broad range of effective, low-cost interventions. While we have been able to win worldwide support, this remains an American initiative, led by traditional U.S. dedication to child health. Mr. Chairman, we need to complete this important work, and it will take but a small amount of designated funds in the foreign assistance appropriations to asure success.

Vitamin A is on the world's public health agenda, a new momentum has been created in the Campaign for Child Survival, and because of the concern of the U.S. Government it is reaching more and more of the children whose sight and lives can be saved. I urge this Select Committee to renew its commitment to a vitamin A earmark for FY '88. You have been instrumental in pushing our Government to its fullest capacity for effecting measures that are life-giving forces for the poorest children on earth. Vitamin A is such a force, and we must not allow any child to be without it.

The need cannot be overstated. While 10 million children develop ocular signs of severe vitamin A deficiency every year, new evidence suggests that the number who are at risk is ten times 10 million. Even with traditional Child Survival strategies like immunization, these children lack protection against a host of respiratory and intestinal diseases. They need immediate vitamin A supplementation.

If we do not provide vitamin A, we can expect an annual toll of 500,000 children with eye signs of vitamin A deficiency so advanced that they become totally blind. That's one child every minute. Most of those die, and millions more succumb before they go blind. These children cannot wait another minute, and Congress should not hesitate another year.

Thank you, Mr. Chairman, for giving me the opportunity to speak on behalf of the malnourished children of the world whose sight and life we can preserve with a strong will and a small amount of funds.

PREPARED STATEMENT OF ALFRED SOMMER, M.D., DIRECTOR AND PROFESSOR, DANA CENTER, WILMER EYE INSTITUTE AND JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH

It is a privilege to return to address the Select Committee on Hunger. The active support and encouragement provided through the Agency for International Development has done much to foster child health and survival among disadvantaged populations in general, and in particular, has strengthened the research and intervention activities of a new approach to the problem that may prove exceedingly important and cost-effective.

A technique we recently developed for detecting early, but physiologically significant vitamin A deficiency, indicates that 5 to 10 times as many children as previously believed may be suffering ill-effects of vitamin A deficiency, an estimated 25 to 50 million children every year. This is in addition to the estimated 5 to 10 million who suffer recognizable eye problems.

The significance of even mild vitamin A deficiency for childrens' health and survival has been emphasized by completion of the study in North Sumatra, Indonesia, where mortality among all children in villages randomized to receive a single, large dose vitamin A supplement once every 6 months was 35% lower than among children living in villages where vitamin A was targeted only to those with obvious eye disease. This very conservative "intent-to-treat" analysis is a measure of the program's effectiveness. Of course not all children in program villages were around to receive their vitamin capsule. When adjusted for those who didn't get it, the potential biologic impact was an astounding 70% reduction in mortality. Alternative

intervention programs, like nutrition education or fortification of a substance all high risk children consume have the potential for achieving the higher figure. Indeed, a greater than 35% reduction in mortality was observed in a recently completed vitamin A fortification program in Western Java, to which we provided technical assistance under a long-standing memorandum of agreement between our Center and the Indonesian Nutrition Research and Development Center. Like the North Sumatra Study this West Java study also found that vitamin A-supplemented children grew better than nonsupplemented children.

The fortification study also confirmed, in a controlled comparison, earlier observations that vitamin A deficiency contributes to anemia (low blood). After one year of fortification hemoglobin values of children in the program area rose by almost 10%.

The mechanism by which vitamin A exerts these beneficial effects is as yet uncertain. But in our studies in Indonesia, and ones that followed in India, mildly vitamin A deficient children were at increased risk of developing respiratory disease, a major childhood killer in third world countries. In Indonesia, vitamin A deficiency was also associated with an increased risk of diarrhea, the other major childhood killer. In Tanzania, where (like much of Africa) measles is a major predisposing cause of childhood deaths, a study we recently conducted with British collaborators demonstrated that children hospitalized with moderate to severe measles randomized to receive high dose vitamin A died at only half the rate of children randomized to the standard hospital regimen. Among the youngest children the differences were even greater. Finally, it was found that even in otherwise well nourished Australian children vitamin A supplementation was effective in reducing the risk of recurrent lower respiratory disease (pneumonia and bronchitis).

These results are not entirely unexpected. They demonstrate in controlled fashion, phenomenae observed in animals for years. That these can pertain to human populations, in such large numbers and so dramatically, has already resulted in a number of official actions by governments and international agencies:

(1) The World Health Assembly voted that WHO give greater attention to the problem as it not only accounts for much blindness in the world, but apparently childhood morbidity and mortality as well.

(2) The Subcommittee on Nutrition of the United Nations Action Coordinating Council (ACC/SCN) concluded that a beneficial effect on child mortality was a likely additional expectation from vitamin A supplementation programs mounted for the control of xerophthalmia.

(3) Based upon the previous work in Indonesia, capped by the recent fortification study, the government of Indonesia concluded just last month that as many as 200,000 Indonesian children could be saved each year from vitamin A supplementation, and laid plans for a nationwide vitamin A fortification program.

(4) Based on the accumulated data, most recently the impact of vitamin A supplementation on measles mortality in Tanzania, UNICEF and WHO have just prepared a joint position paper recommending high dose vitamin A supplementation of all children with measles in communities in which vitamin A deficiency is recognized as a problem, and even where it is not, wherever fatality rates from measles is 1% or higher (a common phenomenon in the developing world, particularly in Africa).

Under a Cooperative Agreement with the Office of Nutrition of USAID, our center has concentrated on carrying out these studies, providing technical assistance in the design and evaluation of intervention programs, educating health officials on the potential importance of vitamin A for the sight, health and survival of their children, and on training local personnel to utilize our newly developed imprint cytology technique to identify communities and populations suffering from mild, but potentially sight and life-threatening vitamin A deficiency. In collaboration with other agencies, particularly the World Health Organization (for whom we are a designated Collaborating Center for the Prevention of Blindness and Vitamin A Deficiency) and PVOs (particularly Helen Keller International), we have designed, field tested and produced a vitamin A deficiency/xerophthaimia recognition, treatment and prevention training aid for health care workers in Asis and Africa, specifically developed to enable local village workers to educate mothers on the importance of breastfeeding and the preparation of vitamin A rich diets.

The potential benefits from vitamin A intervention are enormous, quite possible affecting the nutrition, growth, health and vision of 25 to 50 million children worldwide; and depending upon the severity of vitamin A deficiency and causes of mortality, of preventing as many as 1 to 3 million childhood deaths and one-half million children from going blind worldwide each year.

Spurred by these exciting results, and their implications for a relatively inexpensive, cost-effective approach to improving childrens' health, survival and vision, dozens of countries worldwide are actively considering a wide variety of vitamin A

initiatives. Most programs are in their infancy. They require continued nurturing and support while governments test out the value of vitamin A supplementation for their citizens and devise the most cost-effective means of improving the vitamin A status of their young children. The United States deservedly receives recognition for these remarkable developments. This recognition is accompanied, however, by a very special obligation. U.S. generosity has permitted rapid expansion of research and intervention activities. Continued support is absolutely essential to bring these initiatives for saving childrens' sight and ensuring their survival to fruition.

Thank you for your continuing interest, encouragement and support.

PREPARED STATEMENT OF RUDOLPH VON BERNUTH, DIRECTOR, PROGRAM ADMINISTRATION, CARE

Good morning Mr. Chairman, Honorable Members of Congress, and respected quests and colleagues. My name is Rudy von Bernuth. I've worked with CARE seventeen years, the last three in our New York Headquarters as Director of Program Administration with oversight responsibility for the implementation of CARE's programs worldwide.

CARE is a nonsectarian, nongovernmental, nonprofit development and relief organization presently implementing projects in 39 countries in Latin America, Africa, and Asia. CARE exists to assist poor people to better organize and use their own resources, human and material, toward socio-economic improvement. Special emphasis is placed on local community organization and involvement. Programs are concerned with the human dimensions of both causes and effects of poverty, such as poor nutrition and health, rapid population growth, insufficient and poor quality education, diminishing renewable natural resources, low agricultural productivity, insufficient employment and income generating opportunities, and inadequate community organization.

CARE programs are consistent with national development plans and involve to the fullest extent possible the partnership approach. They provide for timely and flexibile inputs of relevant resources and skills. From project planning through implementation and evaluation, CARE is involved in a cooperative effort with active participation of local communities and such institutions as host government agencies and multilateral and/or private sector organizations.

It is CARE policy that projects represents a joint effort of local institutions, communities, donors and CARE itself. In the case of health projects, the local institution with whom CARE works very closely is often the Ministry of Community Development, Social Services, Human Resource Development, Rural Development or Public Works. In addition, in many countries CARE also enjoys close collaboration with international health agencies such as UNICEF, PAHO, WHO and many sister PVOs working in similar projects in-country. Resources are often pocled and shared among these agencies and counterparts in the areas of training programs, materials, equipment and transportation.

CARE has traditionally had a strong institutional commitment to health. Over the last thirty years, CARE has built health clinics and supplied food to health care institutions; it has also helped train medical personnel by providing specialized physicians, textbooks, equipment and drugs. However, more recently, the program focus has shifted; recognizing the need to improve the quality of community-based services, CARE has turned its efforts toward primary health care.

CARE's Primary Health Care (PHC) sector consists of 73 projects (FY'87) divided among four sub-sectors according to their major components. The sub-sectors are: 1) Water supply and sanitation, 2) Integrated PHC with multiple interventions, excluding food supplements, 3) Education and Training, and 4) Maternal and Child Health projects including PL480 food supplements.

Included in CARE's 73 primary health care projects are six projects funded through the Agency for International Development (AID) Child Survival Program. In 1985, AID funded CARE projects in: Bolivia, Haiti, Indonesia and Uganda. In 1986 projects were funded in Mali and Sudan.

CARE would like to discuss, first of all, the positive impact of Child Survival on our activities. We are convinced that the Child Survival Program has enhanced CARE's efforts in primary health care in several ways. First, the manner in which the Child Survival Program is structured has given CARE the opportunity to standardize, to a certain degree, its approach to health care in six projects. Traditionaliy, CARE primary health care projects have been funded through various donors at diffent times throughout the fiscal year. Child Survival I and II projects are subject to the same donor reporting requirements and start-up time, respectively, across three

continents. These common features among Child Survival projects have allowed CARE the opportunity to develop and test model approaches to Oral Rehydration Therapy and Immunization interventions that are useful to us in other of our ongoing primary health care projects.

Second, an integral part of the Child Survival structure is the detailed implementation plan which is submitted to AID/W during the first year of each Child Survival project. By positioning the creation of a detailed implementation plan in the project's first year, after funding has been secured, something unusual in overseas development work occurs, something with a tremendous positive impact on the integrity of the community development process and the potential success of the projects. The detailed implementation plan opens the door for maximum community and counterpart participation in decision making for the project. It is for this reason that the detailed implementation plan is the primary management tool of Child Survival project managers. In addition, a more focused attempt to consider and carry out evaluation as an on-going process during the life of Child Survival projects is a result of a more participatory approach to the project implementation plan.

Third, included in the Child Survival III guidelines was a list of countries that will remain on the AID/W Child Survival eligibility list. Clearly, knowing the eligible countries in advance allows for maximum planning during the design phase of Child Survival projects. This is seen by CARE as a step forward in the Child Survival program and we anticipate that future Child Survival submissions will benefit from this additional time for project design.

At this point in time it is difficult to state with statistical accuracy how many lives have been saved because of CARE's involvement in Child Survival. What is known, however, is that since funds were allocated in 1985 and 1986, CARE Child Survival projects have provided wider access to and have promoted the increased use of health services in hundreds of communities and for many thousands of mothers and young children. A documented assumption associated with improved access to and use of services is a subsequent improvement in infant, child, and material health indices. CARE has every reason to believe that its Child Survival projects are affecting these indices in a positive way.

Since CARE is not set up as a research oriented institution, it is not realistic to expect statistics regarding disease-specific morbidity and mortality reductions in children 0–5 years old after only three years of project implementation. PVOs, in general, have reputations as implementing agencies. CARE project staff spend the majority of time in primary health care projects delivering services and assisting in the training of counterparts and community members to permanently augment their pool of human resources. CARE depends upon institutions capable of doing research, such as universities, to gather and analyze quantitative data which reflect impact on the lives of children. Research oriented institutions have the personnel, time and financial resources to determine more accurately the number of lives Congressional funds are saving over a relatively short time frame. On the other hand, PVOs focus on the *process* of saving lives in less developed countries. Indeed, the Child Survival Program has build in the capacity to link research with service delivery.

An example of this is the Johns Hopkins University collaboration with PVOs working on Child Survival Programs in Haiti. Johns Hopkins staff will concentrate on documenting the impact of the Child Survival Program in Haiti in terms of numbers of lives saved. CARE and other PVOs will be responsible, to a greater extent, for service delivery and strengthening of local health infrastructures and communities' capacities to carry on, in a sustainable manner, the Child Survival activities.

In the two years that CARE has participated in the Child Survival Program, we have been able to identify several aspects which need to be addressed in order to improve its overall impact.

First, funding for each project needs to be available for a longer period of time. In this year's guidelines for Child Survival proposals, the project period was extended from three to four years, under special circumstances. We welcome this change by AID and would like to recommend that it be extended.

Since many of the specific approaches and requirements of the Child Survival Program are relatively new to CARE, we have viewed the intitial three-year project period as a pilot phase. New interventions are being introduced to communities, new strategies are introduced for working with local counterparts and local communities and new requirements are being introduced to the CARE staff for management and reporting to the donor, AID. In some cases, CARE needs to test out several combinations of new approaches before identifying the one which can be used as a model for expansion within the province, region or country. This process takes time in order to be executed effectively. Therefore CARE, and other PVOs involved

in the Child Survival Program, would like to Congress and AID to consider funding individual projects for at least five years.

Second, the types of indicators used for reporting project progress need to be expanded to adequately reflect the dynamics of local involvement and development. As a corollary to the first point mentioned above, considerable effort is invested in the early years of a project in establishing new counterpart links, working with communities to develop their local management and organizational structures and creating lines of communication, responsibility and authority among all actors in the project. These steps are crucial to the project and must be properly acknowledged since they require considerable time and special indicators to reflect progress. Current Child Survival Program reporting requirements do not fully appreciate the importance and complexity of this community organization phase of the project nor provide indicators for it.

Third, CARE has found that the current group of primarily preventive activities, highlighted by the "twin engines" of diarrhea control and immunizations, has little lasting interest to communities if implemented in a vacuum. The activities need to relate to an overall development program which also addresses other real needs of the community. These needs may be within the health sector, such as simple curative measures or an improved water system. Community needs may also be outside of the health sector, such as support of mothers' clubs for developing income generating activities to support the project as outside input is reduced and eventually withdrawn altogether or to support farmers for improving agriculture production.

Although CARE includes health education for women as a key part of its Primary Health Care projects, we would like to devote more attention, through Child Survival, to the basic education of women. In that way, women would be empowered to make better choices about health. We are heartened that Congress has asked for information regarding the basic education of women in Child Survival projects. CARE has long felt that the basic education and active participation of women in all projects in absolutely crucial to development.

Fourth, technical assistance has been a subject widely discussed in connection with the Child Survival Program. CARE has considerable resources to draw upon in this regard. The most notable are our Primary Health Care Regional Technical Advisors in East and West Africa, Asia and Latin America. These individuals provide technical assistance to CARE's Child Survival projects in a timely and consistent manner. In order to supplement this technical assistance and include "outside perspectives" on CARE's work in health, CARE would like to more actively engage in accessing technical assistance provided through AID for the Child Survival program. CARE recommends, in an effort to strengthen national capacities to provide technical assistance, that AID facilitiate the PVO's abilities to work closely, when possible, with indigenous groups capable of providing appropriate technical assistance.

All of the four points listed above are related to the underlying element of sustainability. This is, in order for projects to become sustainable by communities themselves:

(1) PVOs must have longer periods of time in which to work;

(2) Project progress must be measured in terms of community organization and development, as a prerequisite framework to measuring eventual health impact,

(3) Interventions allowable for Child Survival must be recognized as integral parts of a dynamic community process and therefore should not be implemented in a vacuum, and

(4) Indigenous institutions capable of providing on-going technical assistance in Child Survival countries should be encouraged to participate more fully with PVOs at the field level.

In conclusion, CARE would like to thank the members of Congress, AID, sister PVOs, and field staff who have worked so hard at making the Child Survival Program a mechanism through which improved health for children is becoming a reality in selected countries. After two years involvement in the Child Survivial Program, CARE is confident that the recommendations outlined in this report reflect the extent to which lessons have been learned through the Child Survival experiences. It is CARE's hope that mechanisms for continued dialogue among all parties engaged in Child Survival will become an even greater priority in the future as the number of Child Survival projects increases. Overall, the Child Survival Program is viewed by CARE as being one concrete step toward the commitment made at Alma Ata in 1978 to promote "health for all" by the year 2000. For this we applaud all those responsible.

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